



INDIANA UNIVERSITY SOUTHEAST

DEPARTMENT OF ATHLETICS

Dear Student-Athletes and Parents,

Indiana University Southeast is pleased to have you as a part of the Indiana University Southeast Athletic Program. On behalf of the sports medicine team at Indiana University Southeast we would like to welcome you to our campus. The sports medicine team strives to provide the best quality medical care for our student-athletes. Certified Athletic Trainers and Physical Therapists are available from KORT (Kentucky Orthopedic Rehab Team) for assessment, treatment, and rehabilitation of athletic injuries. Should it be necessary to utilize additional medical consultants, Indiana University Southeast has team physicians available in multiple areas.

Enclosed with this letter is information we would like you to become familiar with so you know what to expect as a student-athlete at Indiana University Southeast. Information enclosed consists of policies regarding insurance reimbursement, consent to treat, privacy policies, and policies regarding discipline and media relations.

Also enclosed are a medical history form, physical examination form, student-information form and insurance information form. These forms must be completed before you may participate as a student-athlete at Indiana University Southeast. In order for you to participate on our sports team, you must have a current pre-participation physical on file with us. **If you do not have a physical by the first day of practice, you will be unable to participate until one is received.**

These forms along with all medical related policies can be downloaded or viewed at the Indiana University Southeast Athletic Department Website at: www.iusathletics.com.

Good luck in the upcoming school year. If you have any questions please feel free to contact us at the numbers below.

Sincerely,

Tiffany Hammond, MS, ATC
Head Athletic Trainer
(812) 941-2099

Joe Glover
Athletic Director
(812) 941-2433



5/11

Dear IU Southeast Student-Athlete,

Norton Healthcare is dedicated to giving back to the community.

Starting July 20, 2011, the Norton Immediate Care Center in Clarksville will be offering Sports Physicals to IU Southeast Student-Athletes at a discounted rate of \$30.00 per student.

IU Southeast will pay the entire \$30.00 on your behalf if you arrive for your physical during the following dates:

Wednesday, July 20	12:00 p.m. – 8:00 p.m.
Wednesday, August 3	12:00 p.m. – 8:00 p.m.
Tuesday, August 30	9:00 a.m. – 8:00 p.m.
Wednesday, August 31	9:00 a.m. – 8:00 p.m.

In request to help us provide complete patient care and satisfaction, we kindly ask that you call ahead to schedule an appointment for your physical. In some cases we may be able to provide same day appointments; however, we strongly recommend calling in before your requested date.

If you arrive at any other date than listed above, you will be responsible for the \$30.00 fee payable at the time of service. You also have the option of going to your primary care physician for your physical at your own cost.

Please bring this letter, your completed sports history physical form and student identification card to the Norton Immediate Care Center located at 2051 Clevidence Blvd. (Located behind Target off Veterans Parkway.)

For additional convenience, we will provide the same service at our following Louisville Immediate Care Center locations:

- KFC Yum! Center, 502.446.5050 (M-F 8AM-6PM, Sat 10AM-4PM), 1 Arena Plaza
- Dorsey Plaza, 502.244.5827, (M-Sun 9AM-9PM), 10284 Shelbyville Rd
- Westport Village, Lyndon, 502.423.7911, (M-Sun 9AM-9PM), 1321 Herr Lane, Suite 195

We are also available to assist you with other healthcare needs through out the year. Our hours of operation are 9 a.m. to 9 p.m. – 7 days a week. Please call 812-282-1720 for further assistance.

Sincerely,

Louette Uhl, RN, BSN
Manager
Norton Immediate Care Center, Clarksville

Thank you for choosing Norton Healthcare.

NORTON IMMEDIATE CARE CENTER REGISTRATION FORM

Date _____

Patient name _____ (last) _____ (first) _____ (m.i) _____ Sex _____ Age _____

Birthdate _____ Social security # _____

Address _____ Apt# _____

City _____ State _____ Zip Code _____

Home Phone(_____) _____ Cell Phone(_____) _____ Work Phone(_____) _____

Can we leave a message about test results on a recorder? _____ Yes _____ No Which #? _____

TO BE COMPLETED BY PARENT OR GUARDIAN IF THE PATIENT IS UNDER 18

Custodial Party _____ Relationship _____

Address _____ Phone (_____) _____

MEDICAL INSURANCE INFORMATION CANNOT BE FILED WITHOUT YOUR CARD, PLEASE GIVE IT TO THE RECEPTIONIST

PRIMARY INSURANCE Company _____

Subscriber (if other than patient) _____ Birthdate _____ Relationship to patient _____

Subscriber SS# _____

Do you have secondary insurance? _____ yes _____ no **If so fill out below and give card to receptionist**

SECONDARY INSURANCE Company _____

Subscriber (if other than patient) _____ Birthdate _____ Relationship to Patient _____

Subscriber SS# _____

PRIMARY CARE PHYSICIAN/PEDIATRICIAN

Name _____ Last _____ First _____ Last Date Seen _____

EMERGENCY CONTACT(Person who does not live with you)

Name _____ Phone _____ Relationship _____

OPTIONAL-OTHER PERSON AUTHORIZED TO DISCUSS YOUR MEDICAL INFORMATION WITH US

Without this information *and* your signature we will not be able to discuss your treatment, condition or medical care with any family/member friend.

I give Immediate Care Center permission to release medical information to the following

person(s) _____ Relationship _____

Signature _____ Date _____

PRIVACY NOTICE

WE AFFIRM OUR COMMITMENT TO COMPLY WITH FEDERAL AND STATE REQUIREMENTS PERTAINING TO THE USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION. A COPY OF OUR POLICY HAS BEEN GIVEN TO YOU.

____ accepted ____ declined ____ rec initials

SIGNATURE _____ **DATE** _____



INDIANA UNIVERSITY SOUTHEAST

DEPARTMENT OF ATHLETICS

Health Insurance Information / Authorization

Student-Athlete's Name _____ Social Security No. _____

Sex Male Female Date of Birth _____ Sport _____

Permanent Address _____

City _____ State _____ Zip _____

Phone # _____ Mobile # _____

Medications currently taking? _____

Allergies/Asthma? _____

Emergency Contact _____ Phone # _____ Relation _____

FATHER'S / GUARDIAN'S INFORMATION	MOTHER'S / GUARDIAN'S INFORMATION
Name _____	Name _____
Home Address _____	Home Address _____
Home Phone _____ DOB _____	Home Phone _____ DOB _____
Employer _____	Employer _____
Work Phone _____	Work Phone _____
Insurance Company _____	Insurance Company _____
Address _____	Address _____
Policy / ID # _____	Policy / ID # _____
Group # _____	Group # _____
Insurance Company Phone # _____	Insurance Company Phone # _____
Type of Insurance- <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity <input type="checkbox"/> Other _____	Type of Insurance- <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Indemnity <input type="checkbox"/> Other _____
Primary Care Physician _____	Primary Care Physician _____
Physician Phone # _____	Physician Phone # _____
Is preauthorization necessary for medical/diagnostic services? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone # _____	Is preauthorization necessary for medical/diagnostic services? <input type="checkbox"/> Yes <input type="checkbox"/> No Phone # _____
Is your son / daughter covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is your son / daughter covered under this policy? <input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE READ CAREFULLY!

- Indiana University Southeast's accident policy provides insurance for student-athletes with **injuries occurring only when participating in the play or practice of intercollegiate athletics**. This accident policy is considered "EXCESS" or "SECONDARY" to any other collectible group insurance benefits. Therefore, any claims for benefits must first be filed with the group insurance company providing coverage. Only after all available benefits have been exhausted will Indiana University Southeast consider payment for any remaining balances.
- I hereby authorize the Indiana University Southeast Department of Athletics, hospitals, & physicians connected with or provided, to furnish information to insurance carriers concerning any illness, injury, & treatments & I hereby assign to the party all payments for medical services rendered to the student-athlete.
- I agree to supply any & all information requested by my primary insurance, Indiana University Southeast & their Risk Management Department in a timely manner.
- I hereby authorize the Indiana University Southeast to secure & inspect copies of case history records, lab reports, diagnoses, x-rays, & any other data pertaining to the injury/illness I am receiving care for or previous confinements of disabilities relevant to the care of the injury/illness.
- I hereby authorize Indiana University Southeast and/or my coach to hospitalize & secure treatment for me for any athletic injury/illness.
- A photocopy of this authorization shall be deemed as effective & valid as the original.
- I agree to notify Indiana University Southeast immediately upon any change in the above health insurance information. If I fail to do so, I fully understand that I may be responsible for any & all charges incurred.
- I hereby certify that I have read & understand the above statements, that any & all questions have been answered to my satisfaction, & that the answers provided are true, complete, & correct to the best of my knowledge.

5/11

Policy Holder's Signature _____	Date _____
Student-Athlete's Signature _____	Date _____



INDIANA UNIVERSITY SOUTHEAST

DEPARTMENT OF ATHLETICS

Consent to Treat and Authorization of Medical Records

I, _____, age _____, while participating in the Indiana University Southeast Athletic Program hereby consent to be treated by the Team Physicians, Athletic Training staff (employees of KORT), or other medical providers recommended by the Team Physician or Athletic Trainer. I understand that participation in intercollegiate athletics does have risks and may result in injury. I further pronounce that unless specifically stated at the time of my athletic physical that to my knowledge I do not have any type of incapacitating condition that may adversely affect my ability to safely participate in intercollegiate athletics.

I understand that Indiana University Southeast will endeavor to assist me in hospital, medical and physician expenses that are the result of participation in intercollegiate athletics and under the guidelines stated in the Indiana University Southeast Athletic Injury Handbook. Indiana University Southeast will also not be responsible for any expense incurred by an athlete that seeks care other than that provided by Indiana University Southeast. I have read and understand the information concerning the coverage provided by Indiana University Risk Management for Indiana University Southeast athletes, which include but are not limited to my responsibility to pay copayments, notifying the athletic trainer of injury, and claims being filed within a 12 month period of injury. I also understand that not following the outlined procedures may result in claims not being paid by Indiana University Risk Management.

I acknowledge that a copy of the Notice of Privacy Practices has been provided to me, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information. I authorize Indiana University Southeast to disclose my medical information with my parent(s)/legal guardian as well as those stated in the Notice of Privacy Practices. I also hereby authorize Indiana University Southeast, the athletic trainer and Indiana University Risk Management to inspect or secure copies of case histories, lab reports, diagnoses, x-rays, and any other medical records and reports on this and/or other previous injuries and/or disabilities.

A copy of this authorization will be considered as effective and valid as the original.

Athlete's Signature

Date

Parent/Guardian Signature
Required if athlete is less than 18 years old

Date



INDIANA UNIVERSITY SOUTHEAST

DEPARTMENT OF ATHLETICS

STUDENT DISCIPLINE POLICIES

I understand that, as a student athlete, I am subject to all Indiana University Southeast student policies. These policies include the policies on substance abuse/illegal drugs, alcohol and tobacco products. I further understand that road trips are “university activities that are being conducted off the university campus” for purposes of policy compliance, and that behavior during road trips is subject to the *IU Code of Student Rights, Responsibilities, and Conduct*. Finally, I understand that the coaches may impose additional policies or team rules. Failure to comply with policies will result in disciplinary action.

The university policies can be found on the Student Affairs web-site at: <http://www.ius.edu/studentaffairs/>

CONSENT FOR RELEASE OF STUDENT AND TEAM STATUS INFORMATION

Students’ education records are protected by the Family Educational Rights and Privacy Act of 1974 (“FERPA”), and they may not be disclosed without your written consent. By your signature below, you authorize Indiana University Southeast to make the following disclosures:

- 1) Academic information (e.g. unofficial transcripts, etc.) may be released to individuals, organizations or agencies for the purpose of determining eligibility or in support for the nomination for awards, special recognition, selection to Kentucky Intercollegiate Athletic Conference (KIAC) or National Association of Intercollegiate Athletics (NAIA) honor teams, etc.
- 2) Educational records, including disciplinary records, may be released to coaches in your sport, administrators, and relevant support staff in the Athletics Department, as well as other university officials with a legitimate educational interest in that information as allowed by FERPA. “Educational records,” as defined by FERPA, include student disciplinary records and grade reports.
- 3) Team status (injured, active, probation, suspension, dismissal) may be released to the media; however, the underlying circumstances and details of any internal University or Athletics Department investigation or disciplinary action shall not be released.

CONSENT FOR MARKETING AND PROMOTIONAL MATERIALS

The Trustees of Indiana University, on behalf of the IU Southeast Athletic Department and the KIAC may wish to produce for resale posters, highlight films, videotapes and other marketing and promotional materials featuring IU Southeast men’s and women’s intercollegiate athletic team members.

I am willing to allow IU Southeast or the KIAC to produce, duplicate, print, broadcast, sell or otherwise use in any manner or media such materials using my picture, likeness, name, or athletic statistics as part of the above described IU Southeast fundraising or promotional projects.

I understand that, as consideration for including my picture, likeness, name or athletic statistics in the project materials, Indiana University or the KIAC shall have all rights and title in these materials, including copyright. I also agree that neither I nor my heirs shall be entitled to any compensation for the use of my picture, likeness, name or athletic statistics in conjunction with these marketing and promotional materials or the accompanying marketing and promotional campaign used by IU Southeast or the KIAC. All such uses shall be consistent with all applicable NAIA and KIAC rules and regulations.

Print First and Last Name

Sport(s)

Signature

Date

**Indiana University Southeast
Student-Athlete Medical History Form**

Name _____ Year in School _____ Sport(s) _____
 Date of Birth _____ Primary Care Physician & Location _____

Disease & Illness	YES	NO	WHEN or WHAT
1. Have you ever experienced an epileptic seizure or been informed that you might have epilepsy?			
2. Have you been treated for infectious mononucleosis, viral pneumonia or any other infectious disease during the past 12 months?			
3. Have you had hepatitis during the past 3 years?			
4. Are you a diabetic?			
5. Have you ever been treated for or been informed by a medical doctor that you have scarlet fever or rheumatic fever?			
6. Have you ever been told you have a heart murmur?			
7. Have you ever become light headed, dizzy or passed out during physical activities?			
8. Have you ever had high blood pressure?			
9. Have you ever had heat related problems (e.g. heat stroke)?			
Head & Neck Injuries			
1. Have you ever had a head injury?			
2. Have you ever been knocked out or unconscious?			
3. Have you ever had a stinger, burner or pinched nerve?			
4. Do you wear eyeglasses, contacts, or blindness?			
5. Do you wear dental appliances?			
Bone & Joint			
1. Have you had a fracture?			
2. Have you ever had a shoulder injury that incapacitated you?			
3. Have you ever been advised to have surgery to correct a shoulder condition?			
4. Have you ever experienced a severe sprain or dislocation of either elbow?			
5. Have you ever had an injury to your back?			
6. Do you ever experience pain in your back?			
7. Have you ever experienced an injury to either knee with severe swelling accompanying an injury?			
8. Have you ever been advised to have surgery to correct a knee condition?			
9. Have you ever experienced a severe sprain of either ankle?			
10. Do you have a pin, plate or screw somewhere in your body as a result of a bone or joint surgery?			
General Medical Data			
1. Have you ever been hospitalized?			
2. Have you ever had surgery?			
3. Are you missing one of any paired organs?			
4. Do you cough or have trouble breathing during or after activity?			
5. Do you currently use any tobacco products on a regular or semi-regular basis?			
6. Have you previously used tobacco products on a regular or semi-regular basis?			
7. Have you ever been diagnosed with any form of asthma?			
8. Do you have a history of sickle-cell anemia in your family?			
9. Do you have any other medical problems			
10. Have you had a medical problem or injury within the last year?			
11. Please list all prescription medications (by name & dose) that you are currently taking.			
12. Please list any medical allergies you have.			
13. Please list any non-medical allergies you have.			
Marfan's Syndrome			
1. Have you ever had chest pain during or after physical activities?			
2. Have you ever had racing of your heart or skipped beats?			
3. Has anyone in your family died of heart problems or sudden death before the age of 50?			
4. Has anyone in your family been diagnosed with Marfan's syndrome?			
Female Athletes Only			
1. What age was your first menstrual period?			
2. When was your last menstrual period?			
3. What was the longest time between menstrual periods?			

I, the undersigned, hereby acknowledge, affirm, and represent that all above statements are true and accurate to the best of my knowledge; and that no answers or information have been withheld. If any information and/or statements are false and/or have been omitted in reference to my past and/or present medical history, I understand and acknowledge that my health and physical welfare may be jeopardized as a result and that I may suffer physical harm.

Student-Athlete Signature _____

Date _____

**Indiana University Southeast
Department of Athletics
Health Examination Form**

Name: _____

Sport(s): _____

Vital Information:

Height: _____

Weight: _____

BP: _____

Pulse: _____

Physical Exam: (To be completed by Examining Physician)

	NORMAL	ABNORMAL FINDINGS
Heart/Cardiovascular	<input type="checkbox"/>	
Lung/Pulmonary	<input type="checkbox"/>	
Abdomen/ Gastrointestinal	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	
Genitalia	<input type="checkbox"/>	
Neck	<input type="checkbox"/>	
Back	<input type="checkbox"/>	
Shoulder	<input type="checkbox"/>	
Elbow	<input type="checkbox"/>	
Wrist/Hand	<input type="checkbox"/>	
Knee	<input type="checkbox"/>	
Ankle/Foot	<input type="checkbox"/>	
Dental	<input type="checkbox"/>	
Eye	<input type="checkbox"/>	

_____/_____/_____

I hereby certify that _____ was examined by me. At this time, the athlete has

- _____ Unrestricted Clearance
- _____ Clearance after completion of further evaluation or rehabilitation
- _____ No Clearance for any of the categories of sports indicated due to an abnormality found in the history or physical examination.

Physician Signature

Date



INDIANA UNIVERSITY SOUTHEAST

DEPARTMENT OF ATHLETICS

Insurance Procedures for Student Athletes and Policy Holders

How to File an Insurance Claim

One of the risks of athletics' is injury. Indiana University Southeast Intercollegiate Athletics Department's insurance provides SUPPLEMENTAL coverage to your primary insurance. The University's insurance pays after all other forms of coverage (i.e., parent's insurance) are made. It also covers only athletics injuries that occur during supervised practices, games, and conditioning sessions. **It will not cover general illness or sickness such as cold, flu, ear aches, etc.**

When an injury occurs, the following procedures should be followed:

1. At the time of medical treatment, the University athletic trainer will assist in supplying your primary insurance and parental information to the health care provider. After action has been taken by the athlete's insurance company, the bill should be sent to the Head Athletic Trainer.
2. The health care provider will send billing statements to the student-athlete or name given on information sheets. This bill must be submitted to the primary insurance carrier of the parents or student-athlete.
3. **Once your primary insurance coverage is exhausted, a statement and explanation of benefits (EOB) must be sent to:**
Indiana University Southeast
Department of Athletics
4201 Grant Line Rd.
New Albany, IN 47150
4. Once Risk Management receives the statement and EOB from your primary insurance company, the claim will be filed with the University's insurance program. Occasionally, the University's insurance program may request additional information from you. Please assist them in their needs.

If you have an HMO or preferred provider-type insurance, you must use only authorized medical vendors from your plan. **If you choose not to use the authorized medical vendors, the Indiana University Southeast Athletics Department and its insurance company will not be responsible for any bills.** Care for an injury incurred while participating in intercollegiate athletics should be completed within **12 months** of the injury date.

Payment of Indiana University Southeast Athletic Bills

The Indiana University Southeast Department of Athletics utilizes a self-insurance program with the Office of Risk Management on student athletes. The program is based on the utilization of the student athlete's insurance assisting in payment of health care costs. The health insurance will be primary pay with Indiana University Southeast paying any unpaid balances, **except copayments**. Please note that Indiana University Southeast is still the **Guarantor**. Those charges not covered by the primary insurance will be covered by the Indiana University Southeast Department of Athletics as long as the health care falls under appropriate policies and procedures.

To take advantage of this policy, please observe the following:

1. The athlete must have an injury report on file at the Department of Athletics.
2. The charges must first be billed to the athlete's primary insurance carrier. The athlete should provide this information upon admission. If the athlete fails to provide this information, please contact the Department of Athletics at (812)941-2099.
3. Show Indiana University Southeast as the secondary carrier and guarantor for any unpaid balances.
4. Send any unpaid balances to Indiana University Southeast Department of Athletics 4201 Grant Line Road, New Albany, IN 47150. Please make sure the bills provide CPT/HCPCS and ICD9 codes for each charge.
5. **The athlete must turn in all unpaid bills to the Indiana University Southeast Athletic Department within 12 months of the injury date in order for them to be paid. Any bills turned in after 12 months of the injury date will not be paid.**

Please call the Indiana University Southeast Athletic Department at (812)941-2099 or Indiana University Risk Management at (812)855-9758 if you have any questions.



INDIANA UNIVERSITY SOUTHEAST

DEPARTMENT OF ATHLETICS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed. Please review it carefully. If you have any questions, please contact our Head Athletic Trainer at the address or telephone number at the bottom of this Notice.

Indiana University Southeast provides health care to our student-athletes in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by all departments and all employed associates, staff or volunteer. In addition, we are a clinically integrated care setting, and we have many doctors and other providers giving care to student-athletes. For convenience of our student-athletes, we are giving one Notice of Privacy Practices to each student-athlete, instead of notices from multiple physicians and other caregivers. This Notice serves as the notice required under Federal law to be given to student-athletes by the Indiana University Southeast, all members of our medical staff and all other health care professionals who treat you at any of our medical facilities. The health care providers covered by this “organized health care arrangement” (“OHCA”) will share protected health information with each other, as necessary to carry out your treatment, payment for treatment, and health care operations relating to the OHCA. This arrangement does not mean that the persons participating in the OHCA are involved in a joint business arrangement, or that they are responsible for the acts of one another.

As a student-athlete at Indiana University Southeast, you have the right to privacy concerning your medical plan of care. Medical record information and your relationship with your medical staff are considered private. Your diagnosis and course of treatment are available only to those directly involved with your care. Unless you tell us otherwise, we will make every effort to give your family medical updates as appropriate. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by our medical staff or your doctor. Your personal doctor may have different policies or notices regarding the doctor’s use and disclosure of your medical information created in the doctor’s office. We are required by law to keep medical information about you private, give you this Notice of our legal duties and privacy practices with respect to medical information about you and follow the terms of the Notice that is currently in effect.

We may use and disclose medical information about you for **treatment** (such as sending medical information about you to a specialist as part as a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company); and **to support our health care operations** (such as comparing patient data to improve treatment methods). We may disclose medical information and/or **participation status to athletic coaches and strength and conditioning coaches for your health and safety**. We may disclose medical information to university administrators and academic counselors to **support your academic progress**. We may release medical information to **sports information staff and members of the media regarding your participation status**. We may release medical information to **professional teams and representatives**.

Regarding your medical information, you have the right to look at or get a copy of medical information that we use to make decisions about your care. You have the right to a personal representative to assist you in reviewing your medical information. If you believe that information in your records is incorrect or incomplete, you have the right to request that we amend the records. You have the right to a list of those instances where we have disclosed medical information about you, other than for treatment, payment, health care operations or where you specifically authorized a disclosure. You may request, in writing, that we do not use or disclose medical information about you for specific cases or circumstances.

We reserve the right change the terms of this Notice at any time. Changes will apply to medical information we already hold, as well as new information we receive after the change occurs. If we change our Notice, we will post the new Notice in our athletic training facilities. You can receive a copy of the current Notice at any time. The effective date is listed just below the title above. You will also be asked to acknowledge in writing your receipt of this Notice.

If you have questions regarding your privacy rights, you may contact our Head Athletic Trainer.

IU Southeast Student-Athlete Questionnaire (Please print all responses)

Full Name _____ Date of Birth _____

What sport(s) are you participating in at IU Southeast?: _____

Student ID Number _____ Hometown Newspaper _____

Campus Address (If applies) _____ Cell Phone Number _____

School E-Mail Address: _____ Personal E-Mail Address: _____

Parent's Names _____ Parent's Email Address: _____

Home Address _____

Hometown _____ State _____ Zip Code _____

High School _____ Year Graduated _____ Previous College _____

Jersey Number (If Applies) _____ Position _____ Height _____ Circle One: FR SO JR SR 5-YR-SR

Do you work (Y/N) _____ If Yes, Where _____ How many hours per week _____

Do you have a Facebook Account: _____ Do you have a Twitter Account: _____ If Yes, Your Twitter Name @ _____

Sports Played in High School:

Sport _____ Years Lettered _____

College Major at IU Southeast: _____ Minor: _____

Please contact me if you have any questions:

Joe Glover, Athletic Director

Indiana University Southeast
Department of Athletics
4201 Grant Line Road
New Albany, IN 47150
Office: 812-941-2028
joglover@indiana.edu
www.iusathletics.com

