SECTION 7 – ACKNOWLEDGEMENT STATEMENT

STUDENT-ATHLETE
ACKNOWLEDGEMENT STATEMENT

By signing below I acknowledge that I have received a copy of the Navajo Technical University student-Athlete Handbook and reviewed the information contained within the Navajo Technical University Student-Athlete Handbook. I understand the contents of the Student-Athlete Handbook and realize that I am subject to disciplinary measures should I violate them. I agree to participate and conduct myself in accordance with the rules of the Navajo Technical University Athletic Department and any other specific rules of Navajo Technical University or the coaches.

I acknowledge that while a student-athlete at Navajo Technical University my photo may be taken. I understand that the Navajo Technical University Athletic Department reserves the right to co-ownership of those photos with the photographer and to use the photos for departmental, promotional and resale purposes. By signing below I consent my photos to be used for departmental, promotional and resale purposes.

I understand that failure to sign and return this form to my Head Coach will result in my being declared temporarily ineligible for practice or competition.

Print Name:
________________________________________________________________________
Your Sport:
________________________________________________________________________
Signature:
________________________________________________________________________
Date:
___________________________________

Acknowledgement:
________________________________________________________________________

Athletic Director/Coach
Sports Physical Form

Name: _________________________________________  Gender:  M  F  Date of Birth: ___/___/___  Father’s Name:

________________________  Daytime phone, pager, cell phone: _______________________  Mother’s Name:

________________________  Daytime, phone, pager, cell phone: _______________________  Street address:

___________________________________________________________________________________  City:

___________________  State: _______  Zip Code: __________  Home phone: ________________________  Alternate

Emergency Contact Person: __________________________  Daytime phone: _______________________  Please indicate

MEDICAL ALERTS such as allergic reactions, contact lenses, etc.:

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________


Medical History:

Athletes and parents: This health record is a critical element in the determination of an athlete’s risk of injury in sports. Please take the time to read and answer all questions before seeing a physician for the athlete’s physical examination.

1. Has anyone in the athlete’s family (grandparents, mother, father, brother, sister, aunt, uncle) died suddenly before age 50? YES  NO  Don’t Know
2. Has the athlete ever stopped exercising because of dizziness or passed out during exercise? YES  NO  Don’t Know
3. Does the athlete have asthma (wheezing), hay fever, or coughing spells after exercise? YES  NO  Don’t Know
4. Has the athlete ever had a broken bone, had to wear a cast, or had an injury to any joint? YES  NO  Don’t Know
5. Does the athlete have a history of concussion (getting knocked out)? YES  NO  Don’t Know
6. Has the athlete ever suffered a heat-related illness (heat stroke)? YES  NO  Don’t Know
7. Does the athlete have a chronic illness or see a doctor regularly for any particular problem? YES  NO  Don’t Know
8. Does the athlete take any medication(s)? YES  NO  Don’t Know
9. Is the athlete allergic to any medications or bee stings? YES  NO  Don’t Know
10. Does the athlete have only one of any paired organs? (Eyes, ears, kidneys, testicles, ovaries) YES  NO  Don’t Know
11. Has the athlete had an injury in the last year that caused the athlete to miss 3 or more consecutive days of practice or competition? YES  NO  Don’t Know
12. Has the athlete had surgery or been hospitalized in the past year? YES  NO  Don’t Know
13. Has the athlete missed more than 5 consecutive days of participation in usual activities because of illness, or has the athlete had a medical illness diagnosed that has not been resolved in the past year? YES  NO  Don’t Know
14. Are you, the athlete, worried about any problem or condition at this time? YES  NO  Don’t Know

Please give details on any “YES” answer from the above health history.
PHYSICAL EXAM – TO BE COMPLETED BY PHYSICIAN

Height __________  Weight __________  Pulse __________  Blood Pressure __________

Vision: R _____ / _____ uncorrected  R _____ / _____ corrected  L _____ / _____ uncorrected  L _____ / _____

corrected

Please Print/ Stamp

Physician’s Name ___________________________________________________________________________________

Street

Address _____________________________________________________________________________________

City, State, Zip Code  _______________________________

Telephone _____________________________________________________________________________________

I certify that I have examined this athlete and found him/her medically qualified to participate in sports. I also certify that I am a licensed medical physician, physician’s assistant, or family nurse practitioner. (Doctor of Chiropractic Medicine is not satisfactory.)

Physician Signature __________________________________________________________ Date ______________________

PARTICIPATION RESTRICTIONS: ________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________
EMERGENCY CONTACT AND PROOF OF INSURANCE

By filling out and signing this form, the parent(s)/guardian(s) are stating that the student athlete is covered by insurance. REMINDER: All student athletes must be covered by insurance before they can plan or practice in a university sponsored sport.

Student Name: ___________________________ Date of Birth: __________

Male: ___ Female: ___ Social Security # ___-__-____ Phone: __________

Home Address: __________________________ City: __________ Zip: __________

Father/Guardian’s Name: __________________ Work Phone: __________

Mother’s Name: __________________________ Work Phone: __________

Primary Health Insurance Company: __________________________

Name of Policy Holder: __________________________

Employer’s Name: __________________________ Group ID# __________

Policy ID#: ______________ Coverage under _____ Self _____ Parent/Guardian

If the student is insured under more than one policy, provide the additional information on the bottom or back of this form.

Date: _______________ Student-Athlete Signature: ______________________

Date: _______________ Parent Signature: ____________________________

Emergency Contact Information

Contact #1: Name________________________ Relation____________________

Address________________________ Home Phone____________________

Work Phone____________ Cellular Phone____________________

Contact #2: Name________________________ Relation____________________

Address________________________ Home Phone____________________

Work Phone____________ Cellular Phone____________________
STUDENT-ATHLETE TRAVEL RELEASE FORM

All individuals are expected to travel to and from competition with their team, unless they have completed this form and provided it to their coach prior to the event. Student-athletes traveling to and from University funded and/or sponsored events must travel with their team or be accompanied by a coach or staff member. The only exception to this policy is if the student-athlete is traveling with a parent or legal guardian. Any alternate travel must be approved using this form. Student-athletes in violation of this policy will be subject to disciplinary action.

<table>
<thead>
<tr>
<th>PERSONAL INFORMATION</th>
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</thead>
<tbody>
<tr>
<td>Student Name:</td>
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<tr>
<td>Home Phone:</td>
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<tr>
<td>Sport(s) You Play:</td>
</tr>
</tbody>
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<tr>
<th>RELEASE REQUEST</th>
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<tbody>
<tr>
<td>Date of Event:</td>
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<tr>
<td>Name of Parent/Legal Guardian:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Signature(s)</th>
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<tbody>
<tr>
<td>Student:</td>
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<tr>
<td>Coach/Staff:</td>
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In accordance with the Family Educational Rights and Privacy Act, I the undersigned, hereby authorize the Faculty Athletics Representative, Athletics Director, and Registrar of the institution I am attending to release any and all information about me which pertains to my eligibility to participate in intercollegiate athletics. The release of such information shall be restricted to any and all official representative of NIRA, only for the purpose of determining my eligibility for intercollegiate athletics. It is further understood that I may receive copies of such material from the institution upon request.

The above statement is applicable for the sport of RODEO for the academic year, 2014/2015.

This form is to be completed in duplicate. The white copy is to be sent by mail or fax to the National Intercollegiate Rodeo Association, with the yellow copy to be retained by the institution.

Print or Type Student’s Name________________________________________________________

Signature of Student_____________________________________________ Date____________________

College or University_______________________________________________________________

Social Security Number_________________________________________ Date of Birth______________
If the college you are currently attending is NOT listed above, was not a member school in 2013/2014, or is not a member school for the year 2014/2015, this document MUST be signed and sealed by the college President or Dean of Students.

<table>
<thead>
<tr>
<th>College / University</th>
<th>Student’s Name</th>
</tr>
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<tbody>
<tr>
<td>hereby certifies</td>
<td></td>
</tr>
<tr>
<td>as a current student and grants permission that he be identified as a student of</td>
<td></td>
</tr>
<tr>
<td>when participating at any NIRA sanctioned rodeos during the 2014-2015 year.</td>
<td></td>
</tr>
</tbody>
</table>

Signature
Title
Date

SCHOOL SEAL

REVISED 6/14
NIRA 2014/2015 - INDIVIDUAL MEMBERSHIP APPLICATION

1. COMPLETE ENTIRE APPLICATION. Incomplete applications will be placed on hold, and you will not be able to compete until your application is complete.
2. Enclose school check, money order, or cashier's check. NO PERSONAL CHECKS ACCEPTED.
3. Enclose a signed high school affidavit with affidavit seal if you are applying for your first NIRA card.
4. Enclose an OFFICIAL transcript from each institution attended, INCLUDING ANY COLLEGE COURSES TAKEN IN HIGH SCHOOL.
5. Enclose a signed Certificate of Clearance.

OFFICE USE ONLY
NIRA# _______________________
Region____________________ School _______________________
Class 1 2 3 4 5 Board Member, ________________________________
Amount Enclosed $______ Pin __________
NIRA belt pins are available for $10.00 each.
Rulebook is $260.00 for dues
Enclosed is $10.00 for rulebook (note: Free copy is available on collegerodeo.com)
Enclosed is $5.00 for RAWHIDE

PARTICIPANT, on this day of __________ 20_________.

INDEMNIFICATION AGREEMENT

I agree to indemnify the NIRA, its officers, directors, employees, agents, NIRA members, contract personnel, and sponsors, for any costs, expenses, and attorneys' fees incurred as a result of my breach of the agreements to waive the claims set forth above.

By my signature I acknowledge and represent that I have read, understand, and agree to the above Waiver of Claims and the Indemnification Agreement.

By signing this application, I am agreeing to the following provisions:

1. APPLICATION UNDERSTANDING AND REFUND POLICY
   • NIRA membership dues are $200.00 per NIRA year. This includes membership fees, medical insurance coverage, Collegiate Arena subscription, and an awards assessment fund of $25. Medical insurance provided by NIRA is mandatory and is excess over any valid and collectible insurance. If the school you are attending are not listed on the back you must pay an additional $5.00.
   • NIRA belt pins are $10.00 each.
   • “Refund Policy” I understand that if I am declared ineligible to obtain a NIRA card or if I void my card, I will not receive a refund.
   • Enclosed is $10.00 for NIRA belt pin
   • Enclosed is $5.00 for RAWHIDE
   • If applicant is under 21 years of age, and their parent(s)/guardian(s) must execute the following affidavit in accordance with the office of the principal.
   • WE HEREBY FULLY ACCEPT THE TERMS OF THIS FULL RELEASE AND ACKNOWLEDGEMENT OF RIGHTS AND AGREE TO BE FULLY BOUND THEREBY ON BEHALF OF PARTICIPANT.

ACKNOWLEDGED AND AGREED TO BY:

X PARTICIPANT, on this day of __________ 20_________.

Acknowledged and agreed to by:

ACKNOWLEDGED AND AGREED TO BY:

X PARENT(S)/GUARDIAN(S) OF PARTICIPANT UNDER THE AGE OF TWENTY-ONE YEAR.

X PARENT(S)/GUARDIAN(S) OF PARTICIPANT UNDER THE AGE OF TWENTY-ONE YEAR.

Total Remitted $______