

Diving Checklist

Welcome to the Longhorn Aquatics community! We're providing the following checklist to help you complete the registration process, and ask that you return required forms to us before your first practice. If you cannot get a physician's authorization by this time, we understand and will allow you to begin practice as long as you return the Physician Authorization Form to us as soon as possible.

Please return the following forms to Longhorn Aquatics:

- 1) TXLA Diving Registration Form____
- 2) Copy of AAU Membership Card____
- 3) Medical Forms
 - Release and Indemnification Agreement____
 - Pre-Activity Clearance Examination: Physician Authorization____
 - Authorization for Release of Medical Information____
 - Consent for Treatment and Medical Insurance Information____
 - Acknowledgement of Receipt of Notice of Privacy Practices____
- 4) Billing Policy____
- 5) Credit Card Authorization Form____

Please keep the following:

- 1) Notice of Privacy Practices
- 2) Copies of forms listed above (you are welcome to make copies of any forms for your own records)

The University of Texas at Austin
Longhorn Aquatics
Registration Form - Diving

PREVIOUS MEMBER YES NO

PLEASE FILL OUT COMPLETELY

PARTICIPANT'S LAST NAME																	
PARTICIPANT'S FIRST NAME											MIDDLE						
DATE OF BIRTH			-			-			SEX:	<input type="checkbox"/> MALE	<input type="checkbox"/> FEMALE						
ADDRESS																	
CITY											STATE			ZIP			
HOME PHONE				-				-									
EMERGENCY PHONE				-				-									
EMERGENCY CONTACT																	
HOUSEHOLD EMAIL ADDRESS																	

IF SOMEONE OTHER THAN PARTICIPANT IS RESPONSIBLE FOR PAYMENT, PLEASE FILL OUT SECTION BELOW

FATHER OR GUARDIAN'S LAST NAME																		
FATHER OR GUARDIAN'S FIRST NAME											MIDDLE							
ADDRESS - IF DIFFERENT FROM ABOVE																		
CITY - IF DIFFERENT FROM ABOVE											STATE			ZIP				
DRIVER'S LICENSE #											STATE							
HOME PHONE				-				WORK PHONE			-							
MOTHER OR GUARDIAN'S LAST NAME																		
MOTHER OR GUARDIAN'S FIRST NAME											MIDDLE							
ADDRESS - IF DIFFERENT FROM ABOVE																		
CITY - IF DIFFERENT FROM ABOVE											STATE			ZIP				
DRIVER'S LICENSE #											STATE							
HOME PHONE				-				WORK PHONE			-							

DESIGNATE FEES AND TRAINING GROUP

GROUP	MONTHLY FEE	PRACTICE TIMES	CHECK GROUP
Team (Coach Recommendation Only)	\$150.00	M-F 3:00-5:00PM or 5:00-7:00PM 4x/week or more (8 hours/week +)	
Intermediate (Coach Recommendation Only)	\$110.00	M-F 3:00-5:00PM or 5:00-7:00PM 3x/week or less (6 hours/week)	
Developmental	\$75.00	M-Th 7:00-8:00PM (4 hours/week)	

***All members must register with AAU before participating.

To register go to www.aausports.org and click on Join Now.
Step 1 - Choose Youth Program Step 2 - \$12 regular membership Step 3 - Diving
Club Name - Longhorn Aquatics Club Code - STDIYTFKB7

VOLUNTEER REQUIREMENTS FOR YEAR

GROUP	HOURS	INITIALS
Team	20 Hours	
Intermediate	12 Hours	
Developmental	8 Hours	

***If volunteer hours are not complete at end of each season, remaining hours will be charged to member at \$12.00 per hour.

A detailed description of the volunteer program can be found in the registration packet.

YEARLY TXLA REGISTRATION	5	0	0	0
1ST MO. TRAINING FEE				
2nd MO. TRAINING FEE				
TOTAL				

START DATE: _____ TSC ID #

MONITOR: _____ DATE: _____

COMMENTS:

*** Yearly TXLA Registration: \$50 September 1 - April 30 and \$20 May 1 - July 31. No fee for joining in August.

THE UNIVERSITY OF TEXAS AT AUSTIN
LONGHORN AQUATICS

RELEASE AND INDEMNIFICATION AGREEMENT

PARTICIPANT: (Name and Address)

INSTITUTION:

The University of Texas at Austin

DESCRIPTION OF ACTIVITY: Competitive Swimming _____ Masters Swim/Dive _____
Competitive Diving _____ College Swimming _____

LOCATION: Lee & Joe Jamail Texas Swimming Center

In consideration of Participant being permitted to participate in the Activity and to use the program's facilities and equipment, I hereby accept all risk to Participant's health and of his/her injury or death that may result from such participation. I hereby release the above named Institution, its governing board, officers, employees and representatives from any and all liability to Participant, Participant's personal representatives, estate, heirs, next of kin, and assigns for any and all claims and causes of action for loss of or damage to Participant's property and for any and all illness or injury to Participant's person, including his/her death, that may result from or occur during Participant's participation in the Activity, whether caused by negligence of the Institution, its governing board, officers, employees, or representatives, or otherwise. I further agree to indemnify and hold harmless the Institution and its governing board, officers, employees, and representatives from liability for the injury or death of any person(s) and damage to property that may result from Participant's negligent or intentional act or omission while participating in the described Activity.

I HAVE CAREFULLY READ THIS AGREEMENT AND UNDERSTAND IT TO BE A RELEASE OF ALL CLAIMS AND CAUSES OF ACTION FOR PARTICIPANT'S INJURY OR DEATH OR DAMAGE TO PARTICIPANT'S PROPERTY THAT OCCURS WHILE PARTICIPATING IN THE DESCRIBED ACTIVITY AND IT OBLIGATES ME TO INDEMNIFY THE PARTIES NAMED FOR ANY LIABILITY FOR INJURY OR DEATH OF ANY PERSON AND DAMAGE TO PROPERTY CAUSED BY PARTICIPANT'S NEGLIGENT OR INTENTIONAL ACT OR OMISSION.

Signature of Participant or Parent/Guardian
of Participant under 18 years of age

Signature of Witness

Address (if different than Participant's)

Date Signed by Witness

Date Signed

THE UNIVERSITY OF TEXAS AT AUSTIN
LONGHORN AQUATICS

PRE-ACTIVITY CLEARANCE EXAMINATION:
PHYSICIAN AUTHORIZATION

I hereby certify that I have examined _____ and have found him/her fit to attend and participate in Longhorn Aquatics. I know of no impairments, which would limit his/her, participation except those that I have listed below. I further certify that he/she is free from any and all contagious diseases.

Restrictions and/or Comments:

Date of Last Tetanus Booster: _____

Date of Physical Examination (**must have been completed within the last 12 months**)

Physician's Signature:

Address:

City, State, Zip:

Phone:

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LONGHORN AQUATICS

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO STAFF

This authorizes The University of Texas at Austin physicians, medical personnel and camp sponsors to release information concerning the medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information of _____(Participant) to camp staff. This information includes injuries or illnesses relevant to participation in the above named camp at The University of Texas at Austin.

The reason for this disclosure is to advise camp staff of the nature, diagnosis, prognosis or treatment concerning any medical condition and any injuries or illnesses Participant may have so that they make decisions regarding Participant's ability and suitability to participate in camp activities. I understand that the entities that receive the information are not health care providers or health plans covered by federal privacy regulations, and that the information described above may be redisclosed publicly and that the information will no longer be protected by those regulations.

I understand that The University of Texas at Austin will not receive compensation for its use/disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by notifying in writing the Departments of Intercollegiate Athletics for Men and Women, but if I do, it will not have any effect on actions The University took in reliance on this authorization prior to receiving the revocation. This authorization expires six years from the date it is signed.

Signature of Participant

Date

Signature of Parent/Legal Guardian
(If participant is under 18 years of age)

Date

Participant's Date of Birth: _____

For: LONGHORN AQUATICS

THE UNIVERSITY OF TEXAS AT AUSTIN
LONGHORN AQUATICS

CONSENT FOR TREATMENT
(Please Print or Type)

Name of
Participant:

Date of Birth:

Address:

City:

State:

Zip:

Parent/Guardian:

Phone Number(s):

Home:

Work:

Mobile:

I, the undersigned, or as the parent or legal guardian of (a minor) hereby authorize such diagnostic, medical and/or surgical treatment of myself or such minor as may be considered necessary or appropriate under the circumstances for the treatment of any illness or injury of the minor. The attending physician, appropriate staff, and The University of Texas at Austin and its officers, regents, and employees shall not be responsible in any way for any consequences from said diagnostic, medical and/or surgical treatment and are hereby released from any and all claims and causes of action that may arise, grow out of, or be incident to such diagnosis, treatment, or surgery insofar as the law allows and provided that these services are performed with ordinary care and to the best of their ability.

Signature of Participant or Parent/Legal
Guardian

Date

PERTINENT MEDICAL/INSURANCE INFORMATION
(to be completed by parents/guardians)

Medical:

Allergies

Current Medications:

Other:

Insurance:

Company:

Policy #:

Social Security or ID #

**THE UNIVERSITY OF TEXAS AT AUSTIN
NOTICE OF PRIVACY PRACTICES**

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

**PLEASE REVIEW IT CAREFULLY.
HIPAA PRIVACY RULES REQUIRE THAT WE FURNISH YOU WITH THIS NOTICE.**

I. Purpose: The University of Texas at Austin’s medical providers, professional staff, employees, and volunteers follow the privacy practices described in this Notice. Your medical information is maintained in records that will be handled in a confidential manner, as required by law. However, UT’s representatives must use and disclose your medical information to the extent necessary to provide you with quality health care. To do this, your medical information must be shared with others as necessary for treatment, payment, and health care operations.

II. What Are Treatment, Payment, and Health Care Operations? Treatment includes sharing information among health care providers involved in your care. For example, your treatment provider may share information about your condition with other treatment providers in clinic and hospital settings in order to make a diagnosis or to improve the quality of care, e.g., for review and training purposes. In addition, we also may use your medical information as required by your insurer to obtain payment for your treatment.

III. What Are Other Ways Your Medical Information May Be Used? Your medical information may be used, unless you ask for restrictions on a specific use of disclosure, for the following purposes:

- Appointment reminders.
- To inform you of treatment alternatives or benefits or services related to your health. (You will have an opportunity to refuse to receive this information.)
- To carry out health care treatment, payment, and operations functions through business associates, e.g., to install a new computer system.
- Worker’s Compensation. (Your medical information regarding benefits for work-related illnesses may be released as appropriate.)
- Health oversight activities, e.g., audits, inspections, investigations, and licensure.
- Certain research projects.
- To prevent a serious threat to health or safety.
- Law enforcement (e.g., in response to a court order or other legal process; to identify or locate an individual being sought by authorities; about the victim of a crime under restricted circumstances; about a death that may be the result of criminal conduct; circumstances relating to reporting information about a crime).

- Disaster relief agency if injured in a disaster.
- National security and intelligence activities.
- Protection of the President or other authorized persons for foreign heads of state, or to conduct special investigations.
- Lawsuits and disputes. (We will attempt to provide you advance notice of a subpoena before disclosing the information.)
- As required by law.

IV. Your Authorization Is Required for Other Disclosures. Except as described above, we will not use or disclose your medical information unless you authorize us in writing to disclose your information. You may revoke your permission, which will be effective only after the date of your written revocation.

V. You Have Rights Regarding Your Medical Information. You have the following rights regarding your medical information, provided that you make a written request to invoke the right.

Right to request restrictions. You may request limitations on your medical information we use or disclose for health care treatment, payment, or operations (e.g., you may ask us not to disclose that you have had a particular treatment), but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency services.

Right to confidential communications. You may request communication in a certain way or at a certain location, but you must specify how or where you wish be contacted.

Right to inspect and request a copy. You have the right to inspect and request a copy of your medical information regarding decisions about your care. We charge a fee for copying, mailing, and supplies. Under limited circumstances, your request may be denied; in that instance you may request review of the denial by another licensed health care professional chosen by UT's medical providers. UT will comply with the outcome of the review.

Right to request amendment. If you believe that the medical information we have about you is incorrect or incomplete, you may request an amendment, which requires certain specific information. UT's medical providers are not required to accept the amendment.

Right to accounting disclosures. You may request a list of the disclosures of your medical information that have been made to persons or entities other than for health care treatment, payment, or operations in the past six (6) years, but not prior to April 14, 2003. After the first request, there will be a charge.

Right to a copy of this Notice. You may request a copy of this Notice at any time, even if you have been provided with an electronic copy.

VI. Requirements Regarding This Notice. The University of Texas at Austin's medical providers are required by law to provide you with this Notice. We will be governed by this Notice for as long as it is in effect. We may change this Notice and these changes will be effective for medical information we have about you as well as any information we receive in the future.

Each time you register for health care services on the University of Texas campus, you may receive a copy of the Notice in effect at the time.

VII. Complaints. If you believe your privacy rights have been violated, you may file a complaint with UT's Sports Medicine Division, with the University's Privacy Officer through the Office of Institutional Compliance, or with the Secretary of the United States Department of Health and Human Services. You will not be penalized or retaliated against in any way for making a complaint to these organizations.

Contact: Call the Office of Institutional Compliance at (512) 232-7055 if:

- You have a complaint.
- You have any questions about this Notice.

Call the Sports Medicine Division at (512) 471-4916/5513 if:

- You wish to request restrictions on uses and disclosures for health care treatment, payment, or operations.
- You wish to obtain forms to exercise your individual rights described in paragraph V.

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**ACKNOWLEDGEMENT OF RECEIPT
OF THE “NOTICE OF PRIVACY PRACTICES”**

I _____ acknowledge that I have received
(print parent/guardian’s name)
a copy of the “**Notice of Privacy Practices**” of *The University of Texas at Austin* as required
by HIPAA privacy rules.

Signature of Parent/Legal Guardian: _____

Participant’s Name (please print): _____

Participant’s DOB: _____ **For:** **LONGHORNS AQUATICS**

The University of Texas at Austin
Longhorn Aquatics
BILLING POLICIES
Effective September 1, 2007.

1. The Longhorn Aquatics (TXLA) Diving and Swimming registration fee is \$50 yearly per family. Members who join between May 1st and July 31st will be charged a prorated registration fee of \$20. Members who join in August will not be charged a yearly fee. All families will pay the \$50 fee each September.
2. Training fees at sign up may be prorated to ½ month if the member joins after the 15th of the calendar month. If a member joins in the last five (5) days of a month and has paid a **full** registration fee and the first and second months' dues in advance, the new member may start those few days early and the training fees paid will be for two full months. Masters Yearly membership dues are **non refundable for any reason**.
3. Members are billed a month of training in advance. All account statements for each month will be mailed on or before the 10th of the previous month. Full payment of account balances is due on or before the 5th of the month for which the dues are payable. Members may elect to use our credit card payment option. Although you will receive a statement for your records, at the end of each month your credit card will be debited any amounts due.
4. There will be \$15.00 late fee charged for any payment received after the 5th of the month. If special consideration is needed, please contact the Business Office and your account will be reviewed.
5. One Month Only Policy: Guests wishing to participate for one month only or for a short duration will pay a prorated fee of \$20 for the TXLA Yearly Registration, plus the appropriate monthly training fee, plus any required NGB Fees. One month age group participants will not be held responsible for voucher fees. Temporary members will not be refunded for any fees for any reason. The Business Office must be notified on the length of stay up front.
6. Members with balances over 30 days old will not be eligible to enter meets until the account is brought current. Balances 60 days overdue will result in termination of membership privileges. **You must contact the Business Office immediately to avoid termination of your membership.**
7. If a member quits the program or is dropped from Longhorn Aquatics due to a delinquent account, overdue and current account balances are immediately due in full. The member will be allowed to rejoin the program only after the past due balance is cleared and a joining fee of \$20.00 is paid. Any exemption of the \$20 fee will be made on a case by case basis.
8. A delinquent account with a balance that is 60 days overdue will be reported to the credit bureau and forwarded to a collection agency for collection efforts. In addition to the delinquent balance owed to Longhorn Aquatics, the member will be responsible for the additional fees charged by the collection agency.
9. Each member will be charged a **full month's dues** for every month in which they compete or attend a training session. Training fees are not refundable for a partial month. Fees will not be prorated under any circumstance other than a **documented medical condition** that would prohibit physical participation. Team members who do not participate in a specific month of training risk losing their spot in their respective practice group. They will be assigned a practice group by the head coach when returning, based on space availability and ability to fulfill practice requirements.
10. A member who will be **out of town** for business/tri-athlete reasons should contact the Business Office 2 weeks before the scheduled leave to adjust their account. Age group members who will be out of practice for 30 consecutive calendar days or more must notify the Business Office 2 weeks before the start of leave to adjust their accounts. Accounts will not be adjusted retroactively regardless of reason. Make sure you receive confirmation from the Business Office in writing/email on your notification or you will be held to the fees.
11. **Any swimmer/diver wishing to drop out of the program must notify Longhorn Aquatics' Administrative Associate in writing or email by the 15th of the month in order to avoid being billed for the next month.** Verbal notice to a coach or anyone other than the Business Office that one plans to discontinue participating in Longhorn Aquatics is not proper notice. If a member is billed unnecessarily and cannot provide proof of termination date, the member will be responsible for all charges on the account(s).

THE UNIVERSITY OF TEXAS AT AUSTIN
LONGHORN AQUATICS

MASTERCARD AND VISA AUTHORIZATION FORM

Please complete the form below and return to the TSC front desk. You may also mail the form to:

University of Texas at Austin
Longhorn Aquatics
1 University Station, D4050
Austin, TX 78712-0364

Longhorn Aquatics Account Number: _____

Athlete(s) name(s): _____

Begin charging effective (date): _____

First Payment Only _____ Every month _____

I, _____, authorize Longhorn Aquatics to charge my MasterCard/Visa for my monthly balance due.

Credit Card (circle one) MasterCard Visa

Name (as it appears on card) _____

Account Number _____

Expiration Date _____

Zip Code _____

Signature _____

Contact phone number or email if there is a problem with card:
