



Incoming Texas Tech University Student-Athletes
CONSENT TO ELECTRONIC SIGNATURE

Throughout this paperwork, you, the student-athlete, or your parent/legal guardian if under the age of 18, will be asked to provide your signature by typing out your full legal name in the spaces provided. By doing so, you certify that the answers provided are correct and complete to the best of your knowledge. Your electronic signature will also be used to certify that you have read, understand, and agree to the policies and statements included in this paperwork. Electronic signatures have the same legal effect can be enforced in the same way as a written signature.

CONSENT TO ELECTRONIC SIGNATURE

I affirm that I have read and understand the electronic signature notice, and I hereby consent to using my electronic signature throughout this document in the manner described above.

Signature: Allyson Dobbs _____

Parent/Guardian Signature if Under 18: _____

Date Signed: 07.17.2025 _____



Incoming Texas Tech University Student-Athletes
DEMOGRAPHICS AND CONTACT INFORMATION

DEMOGRAPHICS

First Name: Allyson Middle Name: Rae Last Name: Dobbs
DOB: 02.16.2007 Age: 18 Race/Ethnicity: White
Gender: Female Marital Status: N/A Spouse Name: N/A
SSN: 627-08-8265 Tech ID (R#): R11999870
Height: 5'10" Weight: 155 Sport Program: Softball

STUDENT-ATHLETE CONTACT INFORMATION

Local Address + City, State, Zip Code (Dorm and Room # or Street/Unit #): 3211 Main Street #146B Lubbock, TX
Email Address: alldobbs@ttu.edu
Cell Phone #: 817-559-3458 Alternative Phone #: _____

PARENT / LEGAL GUARDIAN / EMERGENCY CONTACT CONTACT INFORMATION

Parent/Legal Guardian #1

Full name: Justin Dobbs Relationship to Student-Athlete: Father
Email Address: DobbsJK4@gmail.com Primary Phone # (identify type – cell, work, home): 817-219-1494
Alternative Phone # (identify type): _____ OK to Contact In Event of Emergency (Y/N)? _____
Home Address + City, State, Zip Code: 3617 Pecan Arbor Ct., Granbury, TX 76049

Parent/Legal Guardian #2

Full name: Kelly Dobbs Relationship to Student-Athlete: Mother
Email Address: dobbsPO5@gmail.com Primary Phone # (identify type – cell, work, home): 817-559-5988
Alternative Phone # (identify type): _____ OK to Contact In Event of Emergency (Y/N)? _____
Home Address + City, State, Zip Code: Same as Father

Emergency Contact (Can be Guardian listed above or alternative person; this is who we will contact first)

Full name: Justin and Kelly Dobbs Relationship to Student-Athlete: Parents
Email Address: Same as above Primary Phone # (identify type – cell, work, home): Same as above
Alternative Phone # (identify type): _____
Home Address + City, State, Zip Code: same as above

SEASONS OF COMPETITION – FIVE YEAR RULE

First semester of full-time enrollment at ANY institution (Month/Year): N/A
First semester of full-time enrollment at TEXAS TECH UNIVERSITY (Month/Year): August 2025



Incoming Texas Tech University Student-Athletes
MEDICAL INSURANCE AGREEMENT

Name: Allyson Dobbs

DOB: 2.16. 2007

Sport: Softball

Which describes your designation at Texas Tech University? ☒ Walk on ☐ Scholarship (3% -19%) ☐ Scholarship (20% - Full)

STUDENT-ATHLETES WHO ARE WALK-ONS OR ARE ON SCHOLARSHIPS OF 19% OR LESS:

There are certain requirements for student-athletes who are not on scholarship or receive 19% or less in scholarship.

Each student-athlete who does not have 20% or more scholarship must have their own primary medical insurance and must furnish Sports Medicine within Texas Tech University Athletics Department with evidence that they are currently insured, and the documented medical insurance must have adequate coverage in Lubbock County.

No student-athlete with 19% or less scholarship will be permitted to participate in practice or competition until we have this confirmation. Medical insurance coverage must be kept current at all times while a student-athlete is participating in a sport program within Texas Tech University Athletics Department. Sports Medicine must be notified immediately if your medical insurance coverage changes or lapses at any time. Due to high cost of primary medical insurance, Texas Tech University Athletics Department can only carry secondary medical coverage for student-athletes. Therefore, your medical insurance carrier will always be billed first as the primary carrier.

Texas Tech University Athletics Department may not be responsible for paying for illness or injury to a student-athlete that is not caused by or is a direct result of sport participation. Additionally, Texas Tech University Athletics Department will not be responsible for medical services not provided or recommended by Sports Medicine and team physicians.

Reminder: You must provide a copy of your medical insurance card before you will be permitted to practice or compete. By signing this form, I affirm that I have read, understand, and will adhere to these statements.

Signature: Allyson Dobbs

Parent/Guardian Signature if Required: _____

Date Signed: 07.17.2025



Incoming Texas Tech University Student-Athletes MEDICAL INSURANCE INFORMATION

Name: Allyson Dobbs

DOB: 2.16.2007

Sport: Softball

HEALTH INSURANCE

Name of Insured Party (Subscriber Name): Justin Dobbs

SSN of Insured Party: 637-03-0822

Insured Party's DOB: 09.21.1984

Relationship to Student-Athlete: Father

Insurance Company Name: BCBS

Insurance Phone Number: 1-800-521-2227

Insurance Group Name and Number: 073412

Insurance Claims Address + City, State, Zip Code: PO Box 660247 Dallas, TX 75266

Policy Number (ID#): ZGP835609467

- | | | | | |
|--|-------------------------------------|-----|-------------------------------------|-----|
| 1. Is your insurance company a PPO or HMO? | ☒ | PPO | ☐ | HMO |
| 2. Do you have a prescription card? (please provide a copy) | ☒ | YES | ☐ | NO |
| 3. Do you have Dental Insurance? (please provide a copy) | ☒ | YES | ☐ | NO |
| 4. Does your insurance company require pre-authorization for treatment, MRI, or other scans? | ☐ | YES | ☒ | NO |
| 5. Do you need a referral from your primary care physician to see another doctor? | ☐ | YES | ☒ | NO |

Name of Primary Care Physician: N/A

Phone Number of Primary Care Physician: _____

INSURANCE AUTHORIZATION

- I hereby authorize Texas Tech University Athletics Department to release the above medical insurance information as well as any medical information needed to process a claim on my behalf or my medical expense with my insurance company.
- I hereby authorize that the payment of medical benefits, by my medical insurance company, is made to the health care provider or supplier for the services rendered.

By signing this form, I affirm that I have read, understand, and will adhere to these statements.

Signature: Allyson Dobbs

Parent/Guardian Signature if Required: _____

Date Signed: 07.17.2025



Incoming Texas Tech University Student-Athletes MEDICAL INFORMATION AND LIABILITY RELEASE

Name: Allyson Dobbs

DOB: 02.16.2007

Sport: Softball

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

The Family Education Right of Privacy Act (FERPA) is a federal law that governs the release of student's education records, including personally identifiable information (e.g., name, address, social security number). Texas Tech University has determined that medical information is considered part of a student-athlete's educational record.

This authorization permits Sports Medicine staff from the Athletics Department within Texas Tech University to disclose relevant information concerning my medical status, medical conditions, injuries, prognosis, diagnosis, and related personally identifiable information to the authorized parties below. This information includes injuries or illnesses relevant to past, present, or future participation in athletics while a student-athlete at Texas Tech University.

Note: This authorization does not pertain to the release of mental health information. Please see mental health addendum.

Authorized Parties within Texas Tech University

Coaches	Athletic Department staff	Strength and Conditioning staff
Academic counselors	Medical insurance coordinators	Appropriate university staff
Professors	Dietitians/Nutrition staff	Teammates

Authorized Parties outside Texas Tech University

Media representatives	NCAA	Parents/guardians
The public	Treating healthcare providers	Professional agents
Professional sports organizations	Medical insurance coordinators	Professional scouts

The purpose of a disclosure is to inform the authorized parties of the nature, diagnosis, prognosis, or treatment concerning my medical condition(s) and any injuries or illnesses when relevant. I understand that once the information is disclosed to an authorized party, it is subject to disclosure and is no longer protected by Texas Tech University. I understand that Texas Tech University will not receive compensation for its disclosure of the information. I understand that I may refuse to sign the authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information disclosed under this authorization. I understand that I may revoke this authorization at any time by providing written notification to the Director of Sports Medicine. I understand revocation will not have any effect on actions Texas Tech University has taken in reliance of this authorization prior to them receiving a notice of revocation. This authorization expires seven years from the date it is signed below.

MEDICAL LIABILITY RELEASE

I fully accept all responsibility and assume all risk for my sport participation while at Texas Tech University. I acknowledge receiving a letter concerning the policy that the Athletics Department adheres to regarding medical insurance for student-athletes. I have read and understand the Athletics Department policy as it pertains to financial responsibility when a student-athlete is injured during sport participation at Texas Tech University. I hereby release Texas Tech University, its officials, its coaches, and other employees or agents from any and all claims or action resulting from any and all accidents, illness, or injuries I may sustain while participating in any or all phases of Texas Tech University Athletics Department. A copy of this authorization shall be considered as effective, and as valid as the original.

By signing this form, I affirm that I have read, understand, and will adhere to these statements.

Signature: Allyson Dobbs

Parent/Guardian Signature if Required: _____

Date Signed: 07.17.2025



Incoming Texas Tech University Student-Athletes MEDICAL CONSENT AND TREATMENT AUTHORIZATION

Name: Allyson Dobbs

DOB: 2.16.2007

Sport: Softball

INJURY OR ILLNESS POLICY

Texas Tech University Athletics Department follows the student-athlete injury and illness policy set forth by the NCAA. The Athletics Department will be responsible for medical services on student-athletes if the student-athlete is injured in mandatory or voluntary team activities. The word injury applies only to those ailments that are the direct result of participation in practice or competition. The process for securing medical aid for injury or illness is as follows:

- During the hours of operations for Sports Medicine, you should report the issue in-person to Sports Medicine staff.
- Outside the hours of operations for Sports Medicine, you should contact the appropriate Sports Medicine staff.
- If you are sent to a healthcare provider by Sports Medicine, you will be required to take documentation signed by Sports Medicine to the appointment for the healthcare provider to review and sign. After your visit, you should return that documentation to the appropriate Sports Medicine staff. If you do not take the documentation to the appointment or fail to return it to Sports Medicine, you will be responsible for the expenses associated with the appointment.
- If a healthcare provider gives you a prescription, you should return that documentation to Sports Medicine and they will ensure that it is filled on your behalf. If Sports Medicine has not approved a prescription, you will be responsible for any associated expenses.
- If for any reason you receive a bill from a healthcare provider, please return it immediately to Sports Medicine so that it can be paid.

GUIDELINES FOR MEDICAL EXPENSES

Pursuant to NCAA legislation (Bylaw 16.4.1) Texas Tech University Athletics Department will assume financial responsibility for medical expenses using the following guidelines for any student-athlete who is full-time enrolled and on an active team roster with remaining eligibility. However, please note that in all instances, a student-athlete's insurance will be utilized first as the primary source of payment:

- Expenses resulting from an injury sustained while participating in mandatory or voluntary team activities.
- Expenses resulting from treatment of injury or illness necessary to enable the student-athlete to participate in intercollegiate athletics, regardless of whether the injury or illness was sustained while participating.
- Expenses associated with inpatient or outpatient mental health treatment, or acute hospitalizations for mental health reasons.
- Expenses resulting from eye health examinations and necessary vision correction. Glasses or contacts will be provided, but not both. If contacts are provided, glasses (or vice-versa) may be purchased by the student-athlete.
- Expenses resulting from dental examinations and dental or oral procedures necessary to enable the student-athlete to participate in intercollegiate athletics when approved by the Sr. Associate AD for Health and Wellness. Routine maintenance and cleanings will not be covered. Student-athletes are strongly encouraged to carry dental insurance.
- Expenses for travel associated with transportation to and from out-of-town medical consultations. Expenses for student-athletes will be covered by their respective sport program. Medical expenses associated with a second opinion when approved by the Medical Director and Sr. Associate AD for Health and Wellness.
- Expenses resulting from prescription medications used in the treatment of acute and chronic conditions, including those for reproductive health, mental health, and those used for academic or learning issues.
- Durable medical goods, including custom orthotics and bracing, necessary to enable the student-athlete to participate in intercollegiate athletics.

Medical Expenses: Exclusions

- Expenses associated with elective procedures or surgeries.
- Expenses associated with cosmetic procedures or surgeries.



Incoming Texas Tech University Student-Athletes MEDICAL CONSENT AND TREATMENT AUTHORIZATION

- Expenses associated with consultations, examinations, procedures, treatments, or other interventions that were not authorized by Texas Tech University Athletics Department prior to its occurrence, regardless of whether it was associated with an injury sustained during practice or competition.
- Expenses resulting from medical care for an injury sustained while participating with other teams or programs (e.g., Olympic, Summer League, National Camps), regardless of enrollment and participation status with Texas Tech University Athletics Department.
- Expenses incurred because of intentional or negligent misbehavior of the student-athlete. This includes emergency room visits, hospitalizations, diagnostic tests, laboratory studies, medical evaluations, prescriptions, and other medical expenses.
- Expenses including the diagnosis and treatment of sexually transmitted infections.
- Expenses including prescriptions related to the treatment of dermatological conditions not associated with participation in sports.

Sports Medicine Facility Regulations

- All student-athletes who need treatment or other related services, including taping, must be present at the designated time indicated before you are to be present at practice or competitions.
- If you are not present at the designated time, Sports Medicine will assume you are able and ready for practice or competition.
- Report every injury or illness, even a blister – no matter how trivial it may seem to you at the time. Do not treat an injury or illness yourself – notify Sports Medicine staff and meet with them at an indicated time to evaluate and treat the issue.
- Come to the Sports Medicine facility dressed appropriately (e.g., shirt and shorts) to receive treatment. If it is after practice or competition, shower before coming back into the Sports Medicine facility.
- No student-athlete is to operate Sports Medicine equipment independently of a trained staff member.
- If there are no Sports Medicine staff available because they are assisting other student-athletes, please wait your turn patiently.
- Taking items from the Sports Medicine facility without permission is subject to dismissal from your team.
- No loitering or hanging out in the Sports Medicine facility, as it is a place for evaluation and treatment of medical issues, only.
- You are responsible for all equipment issued to you by Sports Medicine. If it is not returned, you are responsible for its replacement.

AUTHORIZATION FOR MEDICAL TREATMENT

Texas Tech University Athletics Department has its own Sports Medicine program with appropriately trained and licensed professionals. Sports Medicine will provide the majority of evaluation and treatment for injuries or illnesses that occur while you are a student-athlete. Please review the following statements regarding consent for medical treatment by Sports Medicine.

Medical Consent

- **I hereby grant permission to Sports Medicine affiliated team physicians and any consulting physicians to render any treatment or medical or surgical care that they deem reasonably necessary to my health and well-being.**
- **I hereby authorize Sports Medicine athletic trainers, under the direction and guidance of team physicians, to render any preventive, first-aid, rehabilitative or emergency treatment they deem reasonably necessary to my health and well-being.**
- **Also, when necessary for executing such, I grant permission for hospitalization at an accredited hospital.**

Release of Information

While you have agreed to the release of information (if you signed the medical information and liability release), we want to provide further clarification regarding what that looks like when done so by the Texas Tech University Athletics Department.

- You have consented to your medical information concerning illnesses or injuries related to your past, present, or future participation in Athletics at Texas Tech University being released to our internal communications department, and various public media outlets.
- You have consented to your medical information concerning illnesses or injuries related to your past, present, or future participation in Athletics at Texas Tech University being released to your parents or guardians.
- You have consented to your medical information concerning illness or injuries related to your past, present, or future participation in Athletics at Texas Tech University being released to professional sport organizations, scouts, and agents.

As a reminder, this authorization does not pertain to mental health information (please see mental health addendum).

The following are examples of the types of medical information that you have consented being released to the authorized parties:



Incoming Texas Tech University Student-Athletes MEDICAL CONSENT AND TREATMENT AUTHORIZATION

- Current physical health condition
- Illnesses and injuries
- Any treatment, examinations, or hospitalizations
- Medical documents such as x-rays and diagnostic reports

Shared Responsibility of Sports Safety:

While you have already agreed to accept personal risk for any and all participation in Athletics at Texas Tech University, we want to provide further information regarding the responsibility of sports safety by you and by Sports Medicine with the Athletics Department.

- You have acknowledged that participation in Athletics at Texas Tech University requires a personal acceptance of risk and injury.
- You have agreed to rightfully assume that those who are responsible for the conduct of the sport have taken reasonable precaution to minimize such risks, and that your student-athlete peers participating in Athletics will not intentionally inflict injury upon you.

There are periodic analyses of injury patterns done to help in modifications and refinements in the rules and safety decisions for student-athletes. However, to legislate safety via a rule book and equipment standards, while often necessary, seldom is effective by itself; and to rely on officials to enforce compliance with the rule book is as insufficient as to rely on warning labels to produce compliance with safety guidelines. Compliance means respect on everyone's part for the intent and purpose of a rule or guideline.

- **I have read the above shared responsibility statement. I understand that there is certain inherent risk involved in participating in intercollegiate athletics. I acknowledge the fact that there are risks and that I am willing to assume responsibility for such risk while participating in Athletics at Texas Tech University.**

By signing this form, I affirm that I have read, understand, and will adhere to these statements

Signature: Allyson Dobbs

Parent/Guardian Signature if Required: _____

Date Signed: 07.17.2025



Incoming Texas Tech University Student-Athletes MENTAL HEALTH TREATMENT AUTHORIZATION ADDENDUM

Name: Allyson Dobbs

DOB: 2.16.2007

Sport: Softball

Texas Tech University Athletics Department manages the mental health-related information of student-athletes in a different manner than previously discussed regarding medical information. Thus, we have created a mental health addendum, separate from the medical consent and treatment authorization forms. The following outlines your rights and responsibilities for mental health treatment, information on psychological services, limits to confidentiality, and authorization for mental health treatment and consent to electronic communication.

PSYCHOLOGICAL SERVICES

Texas Tech University Athletics Department offers student-athletes clinical and applied psychological services within Sports Medicine.

Mental Health Services

Mental health services include the assessment, identification, and treatment of psychological distress and psychiatric illness via evidence-based practices. All student-athletes will complete the Optimum Performance Evaluation to address mental and behavioral health concerns, as well as learning and academic issues when they arrive on campus to Texas Tech University. Follow up and intervention from this evaluation will be provided as needed at that time. During your time as a student-athlete, you will also have full access to mental health providers. The primary mental health services provided are psychological assessment, psychotherapy, and psychoeducation. Referrals to your team physician or outside providers for medication consultation or management may be utilized as clinically indicated.

Mental Performance Training Exception

Mental performance training is a way in which to develop specific mental skills that can help improve sport performance and outcomes. While Texas Tech University Athletics Department affords you ethical and evidence-based mental performance training, it is not a service that is protected by the rules and regulations set forth by Texas state law. As such, patient rights and responsibilities and limits to confidentiality as outlined in this document do not apply to mental performance training. These services will still be provided by appropriately trained professionals and should be considered in the same manner as other performance services afforded to you as a student-athlete at Texas Tech University Athletics Department, including nutrition and strength and conditioning.

PATIENT RIGHTS AND RESPONSIBILITIES

The following are your rights in mental health treatment as a student-athlete at Texas Tech University Athletics Department:

- You have the right to ethical and evidence-based mental health treatment.
- You have the right to request a different mental health provider if the therapeutic relationship does not fit your needs.
- You have the right to multiculturally competent treatment and should not be discriminated against based on any held identities.
- You have the right to discuss any treatment concerns with your mental health provider at any time.
- You have the right to be involved in planning your treatment and to be informed about your treatment process.
- You have the right to refuse treatment to the extent permitted by law and to be informed of the potential consequences of such.
- You have the right to be provided confidentiality and protection from any unwarranted disclosure regarding your treatment.
- You have the right to request that a copy of your file be made available to other healthcare providers at your written request.

MENTAL HEALTH EMERGENCIES

Texas Tech University Athletics Department provides outpatient mental health services to student-athletes. When acute mental health emergencies arise, Sports Medicine implements a Mental Health Emergency Action Plan, as defined in the Sports Medicine Policy and Procedure Manual. However, with very few exceptions, Sports Medicine only offers mental health services during normal business hours.

If you experience a mental health issue or acute emergency during regular business hours, you agree to do the following:

- Contact your athletic trainer as they can help you set up an appointment with a mental health provider in Sports Medicine.
- Contact any other Athletics staff member that you feel comfortable with, as they can help you get in contact with Sports Medicine.



Incoming Texas Tech University Student-Athletes MENTAL HEALTH TREATMENT AUTHORIZATION ADDENDUM

If you experience an after-hours mental health issue or acute emergency, you agree to do the following:

- Contact your athletic trainer to help support you in determining any potential next steps to address the issue.
- For a non-life-threatening emergency, contact campus police (806-742-3931) or the campus mental health crisis line (806-742-5555).
- For a life-threatening emergency, go immediately to the nearest hospital emergency department (e.g., Covenant) or call 911.

LIMITS TO CONFIDENTIALITY AND TREATMENT AUTHORIZATION

We are required to provide you with the following information and obtain your agreement concerning the privacy of your patient health information and the treatment authorization guidelines established within Texas state law. This information sets forth the specific terms and conditions of the professional engagement as well as the clinical services rendered by the mental health providers within Texas Tech University Athletics Department and constitutes a binding agreement between you and Sports Medicine.

Confidentiality refers to the nature in which your patient health information is protected. Sports Medicine will not share your mental health information with others (except in the limited circumstances outlined below) without your permission. This permission is not being obtained at this time, and instead will be obtained at the specified time it is requested. Below are some of the cases in which Texas state law dictates that your signed authorization may not be required for Sports Medicine to release your information:

- If you seriously threaten to harm yourself, we may be obligated to seek hospitalization, or to contact family members or others involved in your welfare. Texas law provides that we may disclose confidential information to medical or law enforcement personnel if we determine that there is a probability of imminent physical or emotional injury by you to yourself or to others.
- If we have cause to believe that a child under the age of 18 has been or may be abused or neglected in any way, or that a child is a victim of a sexual offense, the law requires that we make a report to the appropriate governmental agency. Additionally, if we have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, the law requires us to make a report to the appropriate governmental agency. Once such a report is filed, we may be required to provide additional information.
- If we have reason to believe that a patient has been the victim of any type of exploitation by a former mental health provider, we are obligated to contact the state licensing board that oversees the professional activities of that provider.
- If a patient is involved in a court proceeding and a request is made for information concerning their diagnosis and treatment, such information is protected under applicable law. However, records may be released pursuant to a validly issued subpoena or court order. If a patient is involved in or contemplating litigation, they should consult with their attorney to determine whether a court would be likely to order us to disclose information.
- In situations where specific legal advice is required to protect your rights as well as our ethical and professional standards, we may choose to seek formal legal advice. Additionally, consultation is a regular component of provision of psychological services, and we may consult with a mental health professional if needed to improve the quality of care we provide. In these cases, we will do what is possible to protect your identity to the best of our legal and ethical responsibility. If we have need to identify you in any way during consultation, treatment planning, or discussion with concerned parties, we will seek consent from you prior to any disclosures.
- If you are a minor under the age of 18, your parent or legal guardian must give permission for us to provide psychological services to you. In this case, your parents/legal guardian are also allowed access to your patient health information. When this applies, we will attempt to clarify all limits of confidentiality and roles within the therapeutic relationship at the onset of our work with you.

Clinical Records

We are legally required to keep records that include specific information obtained during mental health appointments as well as treatment planning, diagnostic considerations, and treatment progress. These records are kept in a secure and encrypted electronic health record. Only Sports Medicine has access to the electronic health record where your mental health information is stored. While on the same system where your medical health information is stored, your mental health information is kept distinctly separate. No other Texas Tech University Athletics Department personnel will have access to your mental health records without your express written permission.

Graduate Training

Sports Medicine has a long-standing relationship with Texas Tech University Psychological Sciences Department, which houses two American Psychological Association accredited doctoral programs in health service psychology. This relationship includes an on-going clinical training rotation for advanced-level graduate students interested in clinical and sport psychology. As such, you may be provided psychological services by these graduate assistants. They are qualified to provide such services, and they will be doing so under the direct supervision and state license of mental health providers within Sports Medicine. This means that to ensure graduate assistants are providing best possible care, they will meet regularly with the supervising licensed mental health provider to discuss and have their work with you signed off on and approved. All other limits to confidentiality will be the same as reported if working with a graduate assistant.



Incoming Texas Tech University Student-Athletes MENTAL HEALTH TREATMENT AUTHORIZATION ADDENDUM

Benefits and Risks

Mental health treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings because the process often requires discussing personal, and often, unpleasant aspects of your life. However, these services have been shown to have benefits for those who undertake it. Engagement in mental health treatment often leads to an overall reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, increased skills for managing stress, and resolutions to specific problems. But there are no guarantees about the outcome of mental health treatment, and it requires a very active effort on your part as the patient.

RELEASE OF INFORMATION

Multidisciplinary Sports Medicine Treatment Team

Sports Medicine is a multidisciplinary treatment setting that includes a primary-care mental health integration model. That means that mental and medical health professionals work together to support your overall health and well-being. As such, information that you disclose to your mental health provider may be shared with other Sports Medicine staff, such as your team physician, athletic trainer, or nutrition staff. Information shared could include attendance history, diagnostic considerations, treatment planning, symptoms, and progress. All Sports Medicine staff is required to afford you confidentiality and protect mental health information differently than medical health information.

Sending Mental Health Records Outside of Texas Tech University

Sports Medicine will not send student-athlete mental health records or release related information verbally to any party outside of Texas Tech University without your express permission. To do so, Sports Medicine will have you complete a formal release of information document, outlining the specific information to be released, the contact information for the authorized party, as well as your signature.

Coaches and Other Texas Tech University Staff

Coaches and other staff members are not privy to your mental health information without your permission. The same procedure listed above will be followed for any formal release of mental health records. However, Sports Medicine, at your request, may support you in verbally discussing basic mental health information with your coaches or other staff. We will document this request in our clinical records.

TREATMENT AUTHORIZATION

By signing below, you affirm that you have read, understand, and agree to the statements in this document related to mental health treatment provided by Sports Medicine while you are a student-athlete for Texas Tech University Athletics Department. While this document will serve as your agreement to treatment, we will provide you with an information sheet and will remind you of limits to confidentiality and what to expect regarding mental health treatment when you arrive for an initial appointment.

Treatment Consent

- I hereby grant permission for Sports Medicine's mental health providers to render any treatment they deem reasonably necessary to support my mental health and well-being.
- I understand my rights and responsibilities as well as the limits to confidentiality as it pertains to mental health treatment.

Agreement to Electronic Communication

- I hereby grant permission for Sports Medicine's mental health providers to contact me via electronic means for scheduling purposes and to distribute relevant educational materials that are intended to support my mental health treatment.
- I understand that electronic communication is not secure, and confidentiality of information cannot be guaranteed.

Signature: Allyson Dobbs

Parent/Guardian Signature if Required: _____

Date Signed: 07.17.2025



Incoming Texas Tech University Student-Athletes MEDICAL HISTORY INTAKE QUESTIONNAIRE

Name: Allyson Dobbs

DOB: 02.16.2007

Sport: Softball

PAST PRIMARY CARE PHYSICIAN AND FORMER COLLEGIATE PARTICIPATION

Doctor's Name: n/a Phone Number: _____

Address + City, State, Zip Code: _____

Have you ever played at or attended another college, university, or junior college? ☐ YES ☒ NO

If yes, where/when? _____

Have you ever NOT passed a physical at another school? ☐ YES ☒ NO

If yes; when/why? _____

PAST MEDICAL HISTORY

1. Have you ever been hospitalized for ANY reason? ☐ YES ☒ NO

If yes; specify date and reason for each episode: _____

2. Have you had ANY type of surgery? ☐ YES ☒ NO

If yes; specify procedure name(s) and date(s) for each episode: _____

3. Has a doctor denied or restricted your participation in sports for any reason? ☐ YES ☒ NO

If yes; explain: _____

4. Are you missing any paired organs (eye, kidney, testicle, etc.)? ☐ YES ☒ NO

5. Do you have any artificial hardware, pins, screw, or implants? ☐ YES ☒ NO

If yes; specify location: _____

6. Have you ever been told to have a surgery or test you did not elect to do? ☐ YES ☒ NO

If yes; explain: _____

7. Have you ever been tested for sickle cell trait? ☐ YES ☒ NO

If yes; was your test normal or abnormal? _____

8. Do you have, or have you had, or have you had treatment for ANY of the following conditions:

ADHD	☐ YES	☒ NO	Heat illness (cramps, heat exhaustion)	☐ YES	☒ NO
Allergies	☐ YES	☒ NO	High blood pressure	☐ YES	☒ NO
Anemia	☐ YES	☒ NO	Learning disability	☐ YES	☒ NO
Anxiety	☐ YES	☒ NO	Leukemia/lymphoma	☐ YES	☒ NO
Asthma	☐ YES	☒ NO	Marfan syndrome	☐ YES	☒ NO
Bladder problems	☐ YES	☒ NO	Menstrual disorder	☐ YES	☒ NO
Bleeding tendencies	☐ YES	☒ NO	Mononucleosis	☐ YES	☒ NO
Cancer	☐ YES	☒ NO	Palpitations/irregular heartbeat	☐ YES	☒ NO
Depression	☐ YES	☒ NO	Pneumonia	☐ YES	☒ NO
Diabetes (type 1 or type 2)	☐ YES	☒ NO	Sickle cell trait or anemia	☐ YES	☒ NO
Exercise induced asthma	☐ YES	☒ NO	Skin infections/staph/MRSA	☐ YES	☒ NO
Fainting/passing out	☐ YES	☒ NO	Sleep apnea	☐ YES	☒ NO
Hearing defect	☐ YES	☒ NO	Spleen injury	☐ YES	☒ NO
Heart Disease	☐ YES	☒ NO	Blood clot or clotting disorder	☐ YES	☒ NO

MEDICATIONS

1. Are you taking ANY prescription medication(s) (i.e. Asthma, Adderall, Mental Health, Birth Control, etc.)? ☐ YES ☒ NO

If yes; list name/dose/how often taken: _____

2. Have you ever been told to take medication that you no longer take? ☐ YES ☒ NO

If yes; specify medication(s): _____



Incoming Texas Tech University Student-Athletes MEDICAL HISTORY INTAKE QUESTIONNAIRE

3. Do you take any over the counter medications regularly? ☐ YES ☒ NO
If yes; specify medication(s): _____
4. Are you taking any supplements (i.e. creatine, vitamins, etc.)? ☐ YES ☒ NO
If yes; specify: _____
5. Do you have any medication allergies? ☐ YES ☒ NO
If yes; list name of medication(s): _____
6. Do you have allergies to any substance (i.e. insects, stings, pollen, food, latex, etc.)? ☐ YES ☒ NO
If yes; specify: _____
7. Have you ever taken anabolic steroids with or without a doctor's prescription? ☐ YES ☒ NO
8. Have you ever had a positive drug test? ☐ YES ☒ NO
If yes; what was it positive for? _____
9. Have you ever been tested for ADHD? ☐ YES ☒ NO
If yes; do you have the results/official report? _____

PERSONAL/SOCIAL

1. Do you use tobacco in any form? ☐ YES ☒ NO
If yes; specify type and frequency: _____
2. Do you drink alcoholic beverages? ☐ YES ☒ NO
If yes; specify quantity of drinks and frequency: _____

FAMILY HISTORY

1. Has anyone in your family died suddenly for no apparent reason? ☐ YES ☒ NO
If so; cause of death: _____
2. Has any family member or relative died of heart problems or of sudden death before age 50? ☐ YES ☒ NO
3. Does anyone in your family have high blood pressure or cardiovascular disease? ☐ YES ☒ NO
4. Does anyone in your family have Marfan syndrome? ☐ YES ☒ NO
5. Does anyone in your family have Sickle Cell Disease or Sickle Cell Trait? ☐ YES ☒ NO
6. Does anyone in your family have Cancer or history of Cancer? ☒ YES ☐ NO
7. Does anyone in your family have a history of mental illness? ☐ YES ☒ NO
If yes; specify: _____

HEAD

1. Have you ever had a concussion or head injury (even if it is not related to sports participation)? ☐ YES ☒ NO
If yes; how many? _____
Were you hospitalized? ☐ YES ☒ NO
Was there any loss of consciousness? ☐ YES ☒ NO
Was there memory loss? ☐ YES ☒ NO
Please describe how each concussion occurred: _____

Please provide dates for each concussion or head injury: _____

How long were you out of participation for each concussion? _____

2. Do you have frequent or severe headaches? ☐ YES ☒ NO
3. Have you been told you have migraine headaches or taken medicine for migraine headaches? ☐ YES ☒ NO
If yes; medications used; doctor's name/address/phone: _____

4. Have you ever had baseline cognitive testing (i.e. IMPACT testing; C3 Logix?) ☐ YES ☒ NO

EYES

1. Have you ever had a problem with your eyes or vision (frequent infections, trauma or surgery, etc.)? ☐ YES ☒ NO
2. Have you ever had a detached retina? ☐ YES ☒ NO
3. Do you wear glasses? ☐ YES ☒ NO
4. Do you wear contacts? ☐ YES ☒ NO
If yes to 3 or 4; please specify prescription strength; hard/soft/disposable, etc. _____

If yes to 3 or 4; doctor's name/address/phone: _____



Incoming Texas Tech University Student-Athletes MEDICAL HISTORY INTAKE QUESTIONNAIRE

4. Have you ever had any type of eye surgery (lazy eye, Lasik, etc.)?

☐ YES

☒ NO

EARS

1. Do you have a history of frequent ear infections?

☐ YES

☒ NO

2. Have you had problems with hearing?

☐ YES

☒ NO

NOSE

1. Do you have hay fever or seasonal allergy symptoms or take medications for allergies?

☐ YES

☒ NO

2. Do you have frequent sinus infections?

☐ YES

☒ NO

3. Do you have frequent nosebleeds?

☐ YES

☒ NO

4. Do you snore, or have you been told that you are a loud snorer?

☐ YES

☒ NO

5. Have you ever fractured your nose?

☐ YES

☒ NO

MOUTH/THROAT

1. Have you ever had any teeth or dental injuries?

☐ YES

☒ NO

2. Do you wear dentures, implants, retainers, etc.?

☒ YES

☐ NO

If yes; explain: _____

Night Retainer

3. Have you ever been told you have "TMJ" syndrome (temporomandibular joint dysfunction)?

☐ YES

☒ NO

If yes; what type of treatment did you receive? _____

4. Do you have frequent throat/tonsil infections or "strep throat"?

☐ YES

☒ NO

5. Have you had your tonsils removed?

☐ YES

☒ NO

NECK

1. Have you ever had a burner, stinger, or pinched nerve?

☐ YES

☒ NO

2. Have you ever had a neck injury that caused you to miss practice or games?

☐ YES

☒ NO

3. Have you ever had a neck injury that caused numbness, burning, tingling, or sharp pain in any arm or hand?

☐ YES

☒ NO

4. Have you ever worn a neck collar because of neck injury?

☐ YES

☒ NO

5. Have you ever had x-rays, CAT scan, or MRI for a neck injury?

☐ YES

☒ NO

6. Have you ever seen a doctor for any type of neck injury?

☐ YES

☒ NO

If yes; why? What tests were done? What were the results? Doctor's name/address/phone: _____

CHEST/RESPIRATORY

1. Do you have asthma?

☐ YES

☒ NO

2. Have you ever been treated with an inhaler or puffer?

☐ YES

☒ NO

3. Do you cough, wheeze, or have difficulty breathing during or after exercise?

☐ YES

☒ NO

4. Have you ever seen a doctor for any type of asthma or respiratory problems?

☐ YES

☒ NO

If yes; why? What tests were done? What were the results? Doctor's name/address/phone: _____

CARDIAC

1. Have you ever passed out during or after exercise?

☐ YES

☒ NO

2. Have you ever passed out for any reason?

☐ YES

☒ NO

3. Have you ever been dizzy during or after exercise?

☐ YES

☒ NO

4. Have you ever had chest pain during or after exercise?

☐ YES

☒ NO

5. Have you ever had racing of your heart or skipped heartbeats?

☐ YES

☒ NO

6. Have you ever been told you have a heart murmur?

☐ YES

☒ NO

7. Has a doctor ever ordered a test for your heart (ECG, echocardiogram, stress test, etc.)?

☐ YES

☒ NO

8. Have you ever been diagnosed or treated for high blood pressure?

☐ YES

☒ NO

If yes; why? What tests were done? What were the results? Doctor's name/address/phone: _____

ABDOMINAL/GASTRO-INTESTINAL

1. Have you ever had any kind of hernia (groin/inguinal, abdominal hernia, sports hernia)?

☐ YES

☒ NO

If yes; did you have surgery? Doctor's name/address/phone: _____



Incoming Texas Tech University Student-Athletes MEDICAL HISTORY INTAKE QUESTIONNAIRE

- | | | |
|---|------------------------------|--|
| 2. Do you have frequent symptoms of heartburn or acid reflux? | ☐ YES | ☒ NO |
| 3. Do you have frequent symptoms of diarrhea/constipation? | ☐ YES | ☒ NO |
| 4. Have you had any type of liver disease or injury? | ☐ YES | ☒ NO |
| 5. Have you ever been diagnosed with any type of hepatitis? | ☐ YES | ☒ NO |
| 6. Have you ever had any type of kidney injury or disease? | ☐ YES | ☒ NO |
| 7. Have you ever had kidney stones? | ☐ YES | ☒ NO |

SKIN

- | | | |
|---|------------------------------|--|
| 1. Do you have, or have you been treated for skin problems? | ☐ YES | ☒ NO |
| a. Problems with itching? | ☐ YES | ☒ NO |
| b. Problems with acne? | ☐ YES | ☒ NO |
| c. Problems with rashes? | ☐ YES | ☒ NO |
| d. Problems with warts? | ☐ YES | ☒ NO |
| e. Problems with fungus? | ☐ YES | ☒ NO |
| f. Problems with blisters? | ☐ YES | ☒ NO |
| g. Problems with staph infections/MRSA? | ☐ YES | ☒ NO |

NEUROLOGICAL

- | | | |
|--|------------------------------|--|
| 1. Have you ever had a seizure? | ☐ YES | ☒ NO |
| 2. Have you ever been diagnosed with meningitis? | ☐ YES | ☒ NO |

MUSCULOSKELETAL/ORTHOPEDIC

- | | | |
|--|------------------------------|--|
| 1. Have you ever dislocated a joint? | ☐ YES | ☒ NO |
| If yes, please specify joint(s): _____ | | |

- | | | |
|---------------------------------------|------------------------------|--|
| 2. Have you ever broken a bone? | ☐ YES | ☒ NO |
| If yes, please specify bone(s): _____ | | |

- | | | |
|--|------------------------------|--|
| 3. Have you ever had a muscle pull/strain? | ☐ YES | ☒ NO |
| If yes, please specify muscle(s): _____ | | |

SHOULDER

- | | | |
|---|------------------------------|--|
| 1. Have you ever had a shoulder injury? | ☐ YES | ☒ NO |
| a. Right/left? _____ | | |
| b. How did the injury occur? _____ | | |
| c. Were x-rays, CAT scan, MRI, or arthrogram done? ☐ YES ☐ NO If yes; date(s); Doctor's name/address/phone: _____ | | |

- | | | |
|---|--|--|
| d. If surgery; Doctor's name/address/phone: _____ | | |
| e. Describe any difficulty you have now: _____ | | |

- | | | |
|--|------------------------------|--|
| 2. Has one of your shoulders ever "come out of place"; subluxation or dislocated? | ☐ YES | ☒ NO |
| a. Right/left? _____ | | |
| b. How did the injury occur? _____ | | |
| c. Were x-rays, CAT scan, or MRI done? ☐ YES ☒ NO | | |
| If yes; date(s); Doctor's name/address/phone: _____ | | |

- | | | |
|---|--|--|
| d. If surgery; Doctor's name/address/phone: _____ | | |
| e. Describe any difficulty you have now: _____ | | |

ELBOW

- | | | |
|--|------------------------------|--|
| 1. Have you had an elbow injury? | ☐ YES | ☒ NO |
| a. Right/left? _____ | | |
| b. How did the injury occur? _____ | | |
| c. Were x-rays, CAT scan, or MRI done? ☐ YES ☒ NO | | |
| If yes; date(s); Doctor's name/address/phone: _____ | | |

- | | | |
|---|------------------------------|--|
| d. Were you put in a cast or immobilized? | ☐ YES | ☒ NO |
| e. If surgery; doctor's name/address/phone: _____ | | |

- | | | |
|--|--|--|
| f. Describe any difficulty you have now: _____ | | |
|--|--|--|



Incoming Texas Tech University Student-Athletes MEDICAL HISTORY INTAKE QUESTIONNAIRE

WRIST/HAND

1. Have you had a wrist/hand injury? ☐ YES ☒ NO
- a. Right/left? _____
- b. How did the injury occur? _____
- c. Were x-rays, CAT scan, or MRI done? ☐ YES ☒ NO
- If yes; date(s); Doctor's name/address/phone: _____
- d. Were you put in a cast or immobilized? ☐ YES ☒ NO
- e. If surgery; doctor's name/address/phone: _____
- f. Describe any difficulty you have now: _____

BACK

1. Have you ever injured your back? ☐ YES ☒ NO
- a. How did the injury occur? _____
- b. Were x-rays, CAT scan, or MRI done? ☐ YES ☒ NO
- If yes; date(s); Doctor's name/address/phone: _____
- c. If surgery; doctor's name/address/phone: _____
- d. Describe any difficulty you have now: _____
2. Have you ever been told you have a congenital spinal defect? ☐ YES ☒ NO
3. Have you ever been told you have spondylosis/spondylolysis/spondylolisthesis? ☐ YES ☒ NO
4. Have you had a low back muscle strain? ☐ YES ☒ NO
5. Have you ever had leg or buttock pain associated with back pain or a back injury? ☐ YES ☒ NO
6. Did you see a physician, chiropractor, or physical therapist for any above condition? ☐ YES ☒ NO
- If yes; doctor's name/address/phone: _____

HIP

1. Have you had a hip injury? ☐ YES ☒ NO
- a. Right/left? _____
- b. How did the injury occur? _____
- c. Were x-rays, CAT scan, or MRI done? ☐ YES ☒ NO
- If yes; date(s); Doctor's name/address/phone: _____
- d. If surgery; doctor's name/address/phone: _____
- e. Describe any difficulty you have now: _____

KNEE

1. Have you had a knee injury? ☐ YES ☒ NO
- a. Right/left? _____
- b. How did the injury occur? _____
- c. Were x-rays, CAT scan, or MRI done? ☐ YES ☒ NO
- If yes; date(s); Doctor's name/address/phone: _____
- d. Were you put in a cast or immobilized? ☐ YES ☒ NO
- e. If surgery; doctor's name/address/phone: _____
- f. Describe any difficulty you have now: _____

ANKLE

1. Have you had an ankle injury? ☐ YES ☒ NO
- a. Right/left? _____
- b. How did the injury occur? _____
- c. Were x-rays, CAT scan, or MRI done? ☐ YES ☒ NO
- If yes; date(s); Doctor's name/address/phone: _____



Incoming Texas Tech University Student-Athletes MEDICAL HISTORY INTAKE QUESTIONNAIRE

d. Were you put in a cast or immobilized? ☐ YES ☒ NO
e. If surgery; doctor's name/address/phone: _____

f. Describe any difficulty you have now: _____
2. Do you have recurrent ankle sprains? ☐ YES ☒ NO

SHINS

1. Have you ever had shin splints? ☐ YES ☒ NO
2. Have you ever had a stress fracture in your lower leg or foot? ☐ YES ☒ NO
3. Have you ever been told you have flat feet or high arches? ☐ YES ☒ NO
4. Have you ever had "turf toe"? ☐ YES ☒ NO
5. Have you ever used orthotics? ☐ YES ☒ NO
6. Did you see a physician or surgeon for any foot problem? ☐ YES ☒ NO
If yes; doctor's name/address/phone: _____

HEAT INJURY HISTORY

1. Have you ever become ill from exercising in the heat? ☐ YES ☒ NO
2. Have you ever been restricted from participation due to heat illness? ☐ YES ☒ NO
3. Do you often cramp during or after exercise? ☐ YES ☒ NO
4. Have you ever had heat stroke or heat exhaustion? ☐ YES ☒ NO
5. Have you ever been hospitalized for any type of heat injury? ☐ YES ☒ NO

EMOTIONAL/PSYCHOLOGICAL

1. Have you ever been told you have ADHD? ☐ YES ☒ NO
If yes; list any medication(s) you are on or were treated with; Doctor's name/address/phone: _____
2. Have you ever been treated for anxiety or depression? ☐ YES ☒ NO
3. Have you ever been told you have an eating disorder? ☐ YES ☒ NO
4. Have you ever been treated for any other mental health issues not listed? ☐ YES ☒ NO
If yes; please specify: _____
5. Have you ever been under the care of a psychiatrist or psychologist or other mental health professional? ☐ YES ☒ NO
If yes; doctor's/provider's name/address/phone: _____

MALE ATHLETE

1. Have you ever had any type of testicular injury or surgery? ☐ YES ☐ NO

FEMALE ATHLETE

1. At what age was your first menstrual period? 15
2. How much time do you usually have from the start of one period to the start of another? MONTH
3. How many periods have you had in the last 12 months? 12
4. Are your menstrual periods painful? ☐ YES ☒ NO
a. If yes, does it require the use of over the counter pain medications? ☐ YES ☒ NO
b. Does your pain limit your activities? ☐ YES ☒ NO
5. Have you seen a doctor for a female health issue? ☐ YES ☒ NO
6. Have you ever had a Pap Smear? ☐ YES ☒ NO
a. If yes, when was your last pap? _____
b. Was it abnormal? ☐ YES ☒ NO
7. Are you taking medicine for cycle regulation or contraception (birth control)? ☐ YES ☒ NO
a. If yes, name the method you are using. _____
b. Were your cycles regular when you started the medicine? ☐ YES ☒ NO
8. Do you need or desire contraception (birth control)? ☐ YES ☒ NO
9. Have you had a breast mass or nipple discharge? ☐ YES ☒ NO

MISCELLANEOUS

1. Have you ever been in a motor vehicle accident (MVA) and suffered injuries that needed medical attention? ☐ YES ☒ NO
If yes; explain: _____
2. Do you have any medical problem(s) not mentioned above? ☐ YES ☒ NO



Incoming Texas Tech University Student-Athletes MEDICAL HISTORY INTAKE QUESTIONNAIRE

If yes; specify: _____

3. Do you have any concerns you would like to discuss with a doctor?

☐ YES

☒ NO

If yes; specify: _____



Incoming Texas Tech University Student-Athletes
FINAL ATTESTATION AND CONSENT

Name: Allyson Dobbs

DOB: 2.16.2007

Sport: Softball

The undersigned, herewith:

- Understands that I must refrain from sport or competition during medical treatment until I am discharged from treatment or given a written permit by the attending physician to resume participation.
- Certifies that the answers to the medical history questions I have provided Texas Tech University are correct and true.
- Understands that having passed the physical examination does not necessarily mean that I will be physically qualified to engage in sport participation at Texas Tech University, but only that the attending examiner did not find a medical reason to disqualify me.
- Fully realizes that Texas Tech University cannot be held responsible for any previous medical condition that I might have.

Signature: Allyson Dobbs

Parent/Guardian Signature if Required: _____

Date Signed: 07.17.2025



WEST TEXAS
HEART & VASCULAR
PLLC

**CARDIAC SCREENING
CONSENT & RELEASE FORM**

Student-Athlete Name: Allyson Dobbs

Team Physician: _____

Activity: Softball

An Electrocardiogram (EKG) Screening and Limited Echocardiogram (ECHO) may help identify athletes who are at risk for sudden cardiac death, a condition where death results from an abrupt loss of heart function. An EKG Screening and Limited Echo may also assist in diagnosing several different heart conditions that may contribute to sudden cardiac death. An EKG Screening and Limited Echo will not prevent sudden cardiac death and does not always detect an abnormality even when it is actually present.

CONSENT TO CARDIAC SCREENING: I hereby voluntarily give my consent to and authorize West Texas Heart & Vascular, PLLC, in Lubbock, Texas, and its employees and contractors to administer, perform and communicate the results of an EKG Screening and Limited Echo.

I understand that sudden cardiac death may still occur, despite this screening. I further understand that an EKG Screening and Limited Echo may not be sufficient for diagnosis purposes and that an additional procedure(s) might be required in the event that an abnormal finding is made on the EKG Screening and/or Limited Echo.

I have had the opportunity to ask questions to West Texas Heart & Vascular, PLLC, and have had my questions answered to my satisfaction.

AUTHORIZATION TO RELEASE SCREENING RESULTS: I hereby authorize West Texas Heart & Vascular, PLLC to release the results of my EKG Screening and Limited Echo to the Texas Tech University Athletics program team physician identified above (Team Physician). I authorize medical personnel to review the EKG and limited Echo results and interpret and use the same for diagnostic purposes.

RELEASE/HOLD HARMLESS: I, for myself, my heirs, and executors, hereby release and hold harmless, West Texas Heart & Vascular, PLLC, its directors, officers, administrators, managers, employees, agents, and contractors from any and all actual or alleged claims, damages, expenses, or liabilities, arising out of, or in any way related to, the EKG Screening or Limited Echo described above.

By signing below, I hereby certify that I have read the foregoing and am the Student-Athlete named above, or am duly authorized by the Student-Athlete as the Student-Athlete's legal representative to execute the above and accept its terms. A photo static copy of this consent and release shall be considered as effective and as valid as the original.

Allyson Dobbs

Student-Athlete or Legal Representative

Relationship If other than Student-Athlete

07.17.2025

Date

Krystal Gage

Witness

07.17.2025

Date

**Pre-Participation Collegiate Athlete Heart Screening
Questionnaire/Evaluation Form**

Allyson Dobbs

Name: Allyson

DOB: 02.16.2007

Sport: Softball

School: Texas Tech

Questionnaire (Explain all "yes" answers)

1. Have you ever been told you have a heart condition?
If yes, explain: _____

☐ YES ☒ NO

2. Has a doctor ever ordered a test for your heart?
If yes, explain: _____

☐ YES ☒ NO

3. Have you ever been told you have a heart murmur?
If yes, explain: _____

☐ YES ☒ NO

4. Have you ever passed out DURING or AFTER exercise?
If yes, explain: _____

☐ YES ☒ NO

5. Have you ever had discomfort, pain, or pressure in
your chest during exercise?
If yes, explain: _____

☐ YES ☒ NO

6. Have you ever been diagnosed with an unexplained
seizure disorder? OR exercised induced asthma not
well controlled by medication?
If yes, explain: _____

☐ YES ☒ NO

7. Do you ever feel inappropriate racing of the heart?
If yes, explain: _____

☐ YES ☒ NO

8. Do you have extreme shortness of breath with
exercise?
If yes, explain: _____

☐ YES ☒ NO

9. Do you have high blood pressure?
If yes, explain: _____

☐ YES ☒ NO

10. Did any of your family members have sudden,
unexpected, or unexplained death before the age of 50
(immediate family-father, mother, brother, or sister)?
If yes, explain: _____

☐ YES ☒ NO

11. Are there any family members who died suddenly of
"heart problems" before the age of 50 (immediate
family- father, mother, brother, or sister)?
If yes, explain: _____

☐ YES ☒ NO

12. Are there any family members who have unexplained
fainting or seizures?
If yes, explain: _____

☐ YES ☒ NO

On-Site heart screening for collegiate athletes

To be completed by medical staff only

Electrocardiogram (ECG):

☐ normal with minor alterations

☐ mildly abnormal

☐ distinctly abnormal

Describe abnormal findings:

Screening Echocardiogram:

☐ structurally normal heart

☐ mildly abnormal (findings consistent with physiological remodeling)

☐ relevant cardiac findings

☐ structural abnormality

☐ valvular abnormality

Describe abnormal findings:

Follow-up:

☐ No Further Diagnostic Testing Indicated

☐ Referral/ Further Diagnostic Testing Indicated

Recommendations/Comments:

Reviewed By Physician: _____

Date: _____