Franciscan SPORTS MEDICINE

Athletic Consents and Authorization Forms

This document contains (1) a consent for Franciscan Alliance (FA) to initiate and provide medical treatment to your student athlete in the event of an injury or illness; (2) an acknowledgement of receipt of FA's Notice of Privacy Practices; (3) a HIPAA Authorization Form; (4) an acknowledgement of your and the student's receipt of written information about concussions and head injuries in student athletes; (5) an acknowledgement of your and the student's receipt of written information about sudden cardiac arrest in student athletes; and (6) an Emergency Medical and Contact Information form. It is very important that you read and complete all of these sections and forms thoroughly and sign all sections/forms separately. If the student athlete is 18 years old or older, he or she must sign for him/herself, except for parent/guardian acknowledgement of receipt of concussion information. Parents may not sign for students who are 18 or older. Failure to follow these instructions may result in exclusion of your child from athletic programs

Consent for Treatment

I consent to FA initiating any medical care or first aid treatment for _____Name of Student Athlete_____ in the event of an accidental injury or an illness. I understand that an attempt will be made to contact me as quickly as possible in such an event. If I cannot be reached, FA may initiate the treatment that FA and its personnel believe to be in the best interest of the above-named student athlete. I acknowledge that I have read this statement, have completed and provided the school with the Emergency Contact Information Sheet, and I hereby give my consent.

Signature of Student Athlete if 18yo or Parent/Guardian if not: _____	*Relationship to Student Athlete:* _____
Printed: _____	*Date:* ___-___-_____

Notice of Privacy Practices

FA has prepared a detailed NOTICE OF PRIVACY PRACTICES (NPP) to help you better understand its policies in regard to your student athlete's personal health information. You have the right to the NPP prior to signing this consent. The current NPP will be available from the Athletic Trainer and posted on FA's website.

Signature of Student Athlete if 18yo or Parent/Guardian if not: _____	*Relationship to Student Athlete:* _____
Printed: _____	*Date:* ___-___-_____

HIPAA Authorization

I hereby authorize FA and its personnel and/or agents, to disclose the protected health information (PHI) of _____Name of Student Athlete_____ (Student) as follows:

The PHI of the Student that may be disclosed under this Authorization includes the records of physical examinations performed by FA to determine the Student's eligibility to participate in classroom or other school sponsored activities; records of the evaluation; records and reports regarding the diagnosis and treatment of injuries which the Student incurred while engaged in school sponsored activities, including but not limited to practice sessions, training and competition; and other records as necessary to determine the Student's physical fitness to participate in school sponsored activities. The Student's PHI may be disclosed to (1) the school principal or assistant principal, athletic director, coaches, teachers, school nurses or other members of the school's administrative staff or their designees, and (2) emergency medical personnel, hospitals or any other health care professional or provider who evaluates, diagnoses

or treats an injury, illness or other condition incurred by the Student while participating in a school sponsored activity, as necessary to:

- Evaluate the Student's eligibility to participate in school sponsored activities, including but not limited to interscholastic or intramural sports programs, physical education classes or other classroom activities;
- Document the sports medicine services provided by FA and evaluate program outcomes;
- Resolve grievances; and
- Evaluate treatment alternatives.

I understand that FA has requested this Authorization to disclose PHI so that the school, together with FA, can make certain decisions about the Student's health and ability to participate in certain classroom and school sponsored activities in accordance with the Health Information Portability and Accountability Act (HIPAA). I also understand that the Student's participation in certain school sponsored activities is conditioned upon my signing this Authorization. I understand that I may revoke this Authorization in writing at any time prior to its expiration date, except to the extent that action has been taken by FA in reliance on this Authorization, by sending a written revocation to the athletic trainer or his/her designee. I understand that the PHI released may be subject to re-disclosure by any recipient and no longer protected by federal and/or state privacy laws. Expiration of Authorization: End of upcoming school year athletic calendar.

Signature of Student Athlete if 18yo or Parent/Guardian if not: _____ *Relationship to Student Athlete:* _____

Printed: _____ *Date:* ___-___-_____

Acknowledgement of Concussion Information

Prior to participating in interscholastic or intramural sports, a high school student and his/her parent or guardian must be given an information sheet regarding the nature and risk of concussions and head injuries to student athletes, including the risks of continuing to play after a concussion or head injury.

I acknowledge that I have received and read the attached information regarding concussions for parents

Signature of Parent/Guardian: _____ *Printed:* _____ *Date:* ___-___-_____

I acknowledge that I have received and read the attached information regarding concussions for student athletes

Signature of Student Athlete: _____ *Printed:* _____ *Date:* ___-___-_____

Acknowledgement of Cardiac Information

Prior to participating in interscholastic or intramural sports, a high school student and his/her parent or guardian must be given an information sheet regarding the nature and risk of sudden cardiac arrest to student athletes.

I acknowledge that I have received and read the attached information regarding sudden cardiac arrest in athletics

Signature of Parent/Guardian: _____ *Printed:* _____ *Date:* ___-___-_____

I acknowledge that I have received and read the attached information regarding sudden cardiac arrest in athletics

Signature of Student Athlete: _____ *Printed:* _____ *Date:* ___-___-_____

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ATHLETE EMERGENCY CONTACT INFORMATION

Last Name: _____ First Name: _____ MI: __ Date of Birth: ___-___-____

School: _____ School Year: _____Grade: _____ Male/Female

Medical Insurance Company: _____ Policy #: _____ Group #: _____

Physician Name: _____Physician Phone #: _____

Preferred Hospital (if any): _____

Current Medication (including Rescue Inhaler or EpiPen): _____

_____

Indicate if the Student Athlete has any of the following conditions:

Asthma or Exercised induced Asthma……Yes No

Diabetes……Yes No

Low Blood Sugar……Yes No

Fainting Spells……Yes No

History of Concussions……Yes No

Seizures……Yes No

Sickle Cell……Yes No

Cardiac Condition……Yes No

Others……Yes No

Date(s)_____

Allergies: _____

Emergency Contact Information

Parent/Guardian #1: Name: _____Relationship to Student:_____

Work phone: _____ Cell phone: _____ Home phone: _____

Parent/Guardian #2: Name: _____Relationship to Student:_____

Work phone: _____ Cell phone: _____ Home phone: _____

Emergency Contacts if Parent/Guardian Cannot Be Reached: Name, Phone Number, and Relationship

1._____

2._____

I hereby state, that to my best knowledge, my answers above are complete, correct, and true.

Signature of Student Athlete if 18yo or Parent/Guardian if not: _____	*Relationship to Student Athlete:* _____
Printed: _____	*Date:* ___-___-____