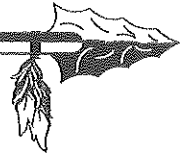


# WAWASEE WARRIOR ATHLETICS

Wawasee High School #1 Warrior Path, Building One • Syracuse, IN 46567  
Phone: 574-325-5133 • Fax: 574-457-4364



## PARENT & ATHLETE INFORMATION

The last 7 (seven) pages of this packet **MUST** be completely filled out and signed in 15 places *and* be returned to the Athletic Office **BEFORE** athletes are able to practice with *any* Wawasee High School athletic team.

Cory Schutz  
Athletic Director

Brent Doty  
Assistant Athletic Director

Andrew Wilson  
Administrative Assistant



# WAWASEE WARRIOR ATHLETICS

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## WAWASEE DRUG TESTING POLICY FOR ATHLETES

All Wawasee High School Athletes are subject to periodic random drug testing if chosen in a random draw by the administering agency. If an athlete tests positive, they are held accountable in accordance with WHS Student Handbook regulations. Suspension from competition for one-third (1/3) of the season is the penalty for a 1<sup>st</sup> offense. Subsequent offenses will lead to harsher penalties, including counseling sessions and possible dismissal from all sports' participation for one calendar year or more.

### PURPOSE OF DRUG TESTING

One of the main components of educating our student-athletes is to teach them the importance of and need for personal accountability. With that purpose in mind, there are three main goals of our drug testing philosophy:

1. To provide for the health and safety of all WHS students and to help athletes to perform to their maximum physical and mental capabilities while on the playing field.
2. To undermine the effects of peer pressure by providing a legitimate reason for students to refuse to use illegal substances.
3. To offer aid to students who are using illegal substances and help them to stop.

### ANONYMITY

Every effort is made to protect the reputation and privacy rights of every individual who participates in the program. Results are only made known to WHS administration who then will only discuss the results and consequences with the athlete, their parents, their head coach, and the chosen counseling service should one be required. Results will not be documented in any personal files of the student, will not be reflected in any manner academically, and neither criminal nor juvenile authorities will be contacted.

### PROCEDURES

All athletes' names will be submitted to the testing agency for random drawing several times throughout the school year. If drawn, it is expected that the chosen athlete will cooperate and participate in all testing procedures. Unless the student presents administration with a medical or some other valid excuse for not participating that day, non-participation will assume an

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admittance of a violation of our drug policy and will be subject to disciplinary action. The same student may be chosen more than once per year for testing and is expected to cooperate and pass each testing event by providing a fresh urine sample. The cost of the testing is covered by the school and the student is not charged for the procedure. Required counseling sessions by local agencies designated by the school for second time offenders will be paid for by the Athletic Department. Counseling by non-school designees must first be approved by the Athletic Department and paid for by the individual.

Students cannot be recommended for testing by school or athletic personnel. If school authorities suspect the need for testing, they must call the parents first to request permission to test the athlete. Parents are the only ones who can request a test of their son or daughter.

Upon selection, the student will be asked to provide information for and sign forms prepared by the testing agency. Tests will usually be given in seclusion on school grounds. Students will be informed of the need to test in as private a manner as possible. The student will be provided a bottle and allowed to go into a secluded area to give a sample. If the student has difficulty giving a sample, they will be allowed extra time. When finished, the agency will seal the container and ready it for shipment to the lab for analysis. Instead of a name, the sample will be labeled with a private identification number. If the seal becomes broken during such time, that sample is considered contaminated and the student will be asked to provide another sample as soon as possible.

## RESULTS

A result sheet for all the students tested that session will be mailed to the Principal or their designee by the lab. Again, only identification numbers will appear on the results sheet. The Principal will contact the Athletic Director if any athletes should test positive. The Athletic Director will then inform the athlete, parents, and head coach of any negative results and the appropriate actions to be taken. If the student is not contacted by administration after testing, it should be assumed that the results returned were positive and there is no need to meet.

# HEADS+UP

## CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **ATHLETES**

### Concussion facts:

- A concussion is a brain injury that affects how your brain works.
- A concussion is caused by a bump, blow, or jolt to the head or body.
- A concussion can happen even if you haven't been knocked out.
- If you think you have a concussion, you should not return to play on the day of the injury and not until a health care professional says you are OK to return to play.

### What are the symptoms of a concussion?

Concussion symptoms differ with each person and with each injury, and they may not be noticeable for hours or days. Common symptoms include:

- Headache
- Confusion
- Difficulty remembering or paying attention
- Balance problems or dizziness
- Feeling sluggish, hazy, foggy, or groggy
- Feeling irritable, more emotional, or "down"
- Nausea or vomiting
- Bothered by light or noise
- Double or blurry vision
- Slowed reaction time
- Sleep problems
- Loss of consciousness

During recovery, exercising or activities that involve a lot of concentration (such as studying, working on the computer, or playing video games) may cause concussion symptoms to reappear or get worse.

### What should I do if I think I have a concussion?

**DON'T HIDE IT. REPORT IT.** Ignoring your symptoms and trying to "tough it out" often makes symptoms worse. Tell your coach, parent, and athletic trainer if you think you or one of your teammates may have a concussion. Don't let anyone pressure you into continuing to practice or play with a concussion.

**GET CHECKED OUT.** Only a health care professional can tell if you have a concussion and when it's OK to return to play. Sports have injury timeouts and player substitutions so that you can get checked out and the team can perform at its best. The sooner you get checked out, the sooner you may be able to safely return to play.

**TAKE CARE OF YOUR BRAIN.** A concussion can affect your ability to do schoolwork and other activities. Most athletes with a concussion get better and return to sports, but it is important to rest and give your brain time to heal. A repeat concussion that occurs while your brain is still healing can cause long-term problems that may change your life forever.

### How can I help prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Follow your coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

### If you think you have a concussion:

Don't hide it. Report it. Take time to recover.

**It's better to miss one game than the whole season.**

For more information, visit [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).



# HEADS+UP

## CONCUSSION IN HIGH SCHOOL SPORTS

A FACT SHEET FOR **PARENTS**

### What is a concussion?

A concussion is a type of traumatic brain injury. Concussions are caused by a bump or blow to the head. Even a “ding,” “getting your bell rung,” or what seems to be a mild bump or blow to the head can be serious.

You can’t see a concussion. Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days or weeks after the injury. If your child reports any symptoms of concussion, or if you notice the symptoms yourself, seek medical attention right away.

### What are the signs and symptoms of a concussion?

If your child has experienced a bump or blow to the head during a game or practice, look for any of the following signs of a concussion:

SYMPTOMS REPORTED BY ATHLETE	SIGNS OBSERVED BY PARENTS/GUARDIANS
<ul style="list-style-type: none"> <li>• Headache or “pressure” in head</li> <li>• Nausea or vomiting</li> <li>• Balance problems or dizziness</li> <li>• Double or blurry vision</li> <li>• Sensitivity to light</li> <li>• Sensitivity to noise</li> <li>• Feeling sluggish, hazy, foggy, or groggy</li> <li>• Concentration or memory problems</li> <li>• Confusion</li> <li>• Just “not feeling right” or “feeling down”</li> </ul>	<ul style="list-style-type: none"> <li>• Appears dazed or stunned</li> <li>• Is confused about assignment or position</li> <li>• Forgets an instruction</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily</li> <li>• Answers questions slowly</li> <li>• Loses consciousness (even briefly)</li> <li>• Shows mood, behavior, or personality changes</li> </ul>

### How can you help your child prevent a concussion or other serious brain injury?

- Ensure that they follow their coach’s rules for safety and the rules of the sport.
- Encourage them to practice good sportsmanship at all times.
- Make sure they wear the right protective equipment for their activity. Protective equipment should fit properly and be well maintained.
- Wearing a helmet is a must to reduce the risk of a serious brain injury or skull fracture.
  - However, helmets are not designed to prevent concussions. There is no “concussion-proof” helmet. So, even with a helmet, it is important for kids and teens to avoid hits to the head.

### What should you do if you think your child has a concussion?

**SEEK MEDICAL ATTENTION RIGHT AWAY.** A health care professional will be able to decide how serious the concussion is and when it is safe for your child to return to regular activities, including sports.

**KEEP YOUR CHILD OUT OF PLAY.** Concussions take time to heal. Don’t let your child return to play the day of the injury and until a health care professional says it’s OK. Children who return to play too soon—while the brain is still healing—risk a greater chance of having a repeat concussion. Repeat or later concussions can be very serious. They can cause permanent brain damage, affecting your child for a lifetime.

**TELL YOUR CHILD’S COACH ABOUT ANY PREVIOUS CONCUSSION.** Coaches should know if your child had a previous concussion. Your child’s coach may not know about a concussion your child received in another sport or activity unless you tell the coach.

**If you think your teen has a concussion:**  
Don’t assess it yourself. Take him/her out of play. Seek the advice of a health care professional.

**It’s better to miss one game than the whole season.**

For more information, visit [www.cdc.gov/Concussion](http://www.cdc.gov/Concussion).



## Head Injury Management Plan

A head injury management plan should be used to improve the care of head injuries in patients.

### Baseline Testing

The Centers for Disease Control and Prevention recommends that contact and collision sport athletes take a pre-season baseline to establish their baseline level of memory, reaction time, and processing speed. PSM provides assistance with baseline testing.

### Post-Injury Evaluation

Patients should complete the post test correlating with their most recent baseline test within five days of their head injury if not under the care of a physician.

Following an injury, patients should be under the care of a physician if:

- Concussion symptoms are not improving within five days
- Post-concussion evaluation results do not return to baseline within five days

Physical therapy for cervical facet/vestibular rehabilitation may be an option for symptoms lasting more than seven days.

### Return-to-Play Guidelines:

According to the "Student Athletes: Concussions and Head Injuries" law (IC 20-34-7), an athlete suspected of having suffered a concussion may not return to play (RTP) until:

- The patient has been evaluated by a licensed healthcare provider trained in the evaluation and management of concussions.
- The patient receives written clearance for RTP from the licensed healthcare provider who initially performed the evaluation. Written clearance must also be provided to the student athlete's high school athletic department and/or athletic trainer.
- A minimum of 24 hours has passed since the patient was removed from play.

Patients must also complete the following steps before they can RTP. A patient must review and answer the PSM symptom checklist following each step before they can move on to the next step. Each step is monitored and progression is managed by a health care professional trained in the management of concussion.

If a patient presents an increase in their Symptom Score to greater than 10 during, or after completing, a step, they must rest for 24 hours and repeat the step until they are able to pass the PSM symptom checklist guidelines (see below). If the patient does not move to the next step within three days, a referral to or follow up with a physician is required. Multiple steps cannot be completed on the same day.

- **RTP Form on file with athletic trainer.** If no post test was completed during the physician evaluation, post test must be completed and symptom checklist reviewed before moving on to activity phase. This may be completed on the same day as Step 1.
- Return to activities of daily living without symptoms before returning to exercise.
- **Step 1 – Light aerobic exercise.** The patient must be able to perform, at minimum, a 20-minute workout on an exercise bike, walking, or light jogging; but no weight lifting, jumping or hard running. No resistance training.
- **Step 2 – Moderate exercise.** The patient must be able to participate using limited practice equipment (if applicable), as well as any moderate activities that incorporate sport-specific drills like interval sprinting, push-ups, sit-ups, squat thrusts and more.
- **Step 3 – Heavy exercise; non-contact physical activity.** The patient must be able to participate using practice equipment, and in all non-contact activities. No impact activities should be done at this stage. Sprinting, running, high-intensity exercise bike, and weight lifting; but no contact sports. Resistance training may begin at this time.
- **Step 4 – Full contact practice.** The patient reports no increased symptoms on the symptom checklist and must be able to participate in full-contact practice. Full-contact practice does not include scrimmages, games or competition.

Patients may RTP upon successful completion of all four steps.

Return to baseline standards (unless otherwise directed by a physician):

\*\*SCAT 5 – Return to baseline definition is within 1 point of baseline score

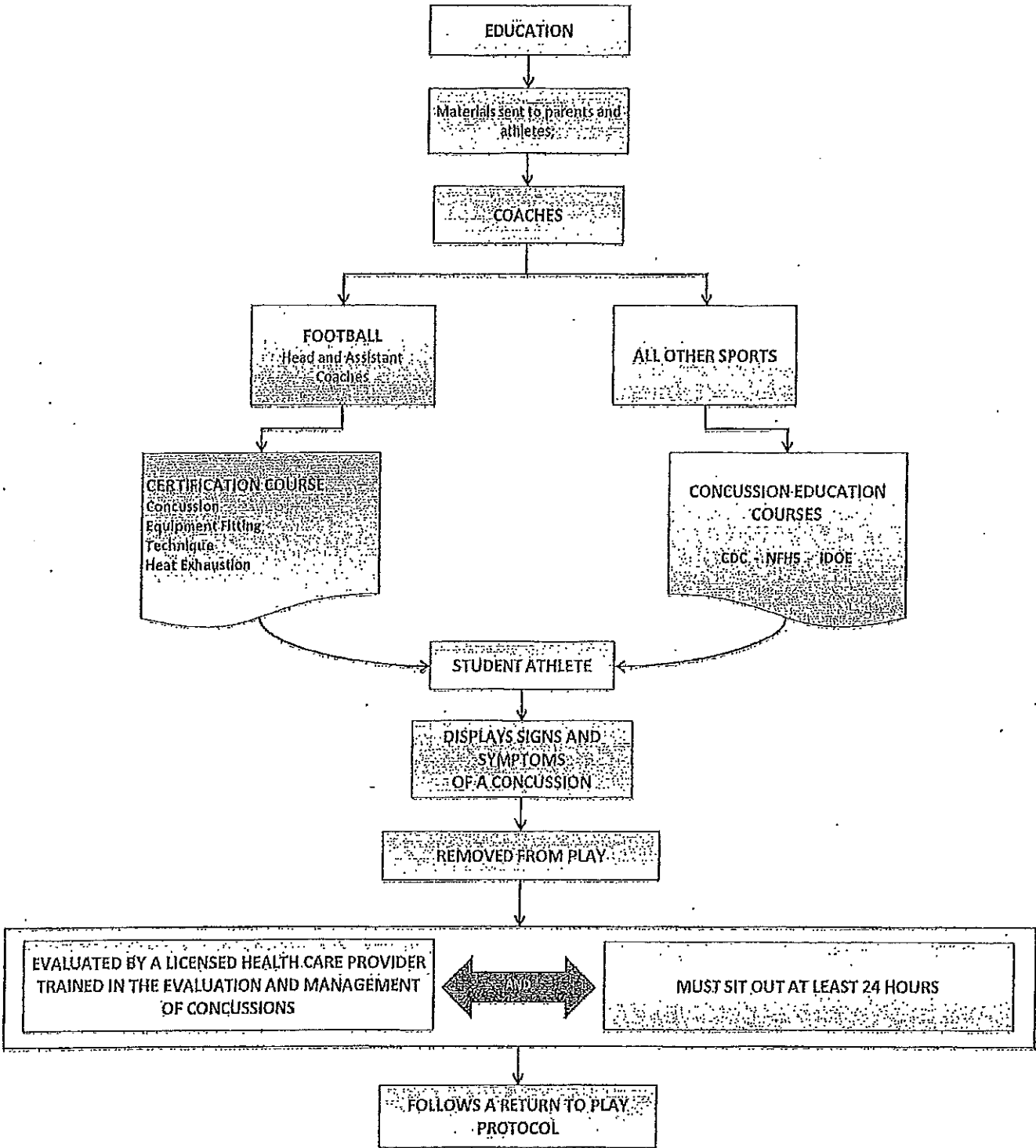
\*\*ImPACT – Return to baseline definition is no red composite scores

\*\*Symptom checklist – Return to baseline definition is a total symptom score less than 10

\*\*Other testing methods (SAC, BESS, etc) should follow manufacturer's guidelines



**CONCUSSION FLOWCHART FOR STUDENT ATHLETES PER IC 20-34-7**



**NOTE:** Boxes shaded in "red" indicate new legislation that will become effective July 1, 2014

# **SUDDEN CARDIAC ARREST**

## *A Fact Sheet for Student Athletes*

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### **FACTS**

Sudden cardiac arrest can occur even in athletes who are in peak shape. Approximately 500 deaths are attributed to sudden cardiac arrest in athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest. Once a cardiac arrest occurs, there is very little time to save the athlete, so identifying those at risk before the arrest occurs is a key factor in prevention.

### **WARNING SIGNS**

There may not be any noticeable symptoms before a person experiences loss of consciousness and a full cardiac arrest (no pulse and no breathing).

Warning signs can include a complaint of:

- Chest Discomfort
- Unusual Shortness of Breath
- Racing or Irregular Heartbeat
- Fainting or Passing Out

### **EMERGENCY SIGNS – Call EMS (911)**

If a person experiences any of the following signs, call EMS (911) immediately:

- *If an athlete collapses suddenly during competition*
- *If a blow to the chest from a ball, puck or another player precedes an athlete's complaints of any of the warning signs of sudden cardiac arrest*
- *If an athlete does not look or feel right and you are just not sure*

### **How can I help prevent a sudden cardiac arrest?**

Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, you can assist by:

- Knowing if you have a family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age)
- Telling your health care provider during your pre-season physical about any unusual symptoms of chest discomfort, shortness of breath, racing or irregular heartbeat, or feeling faint, especially if you feel these symptoms with physical activity
- Taking only prescription drugs that are prescribed to you by your health care provider
- Being aware that the inappropriate use of prescription medications or energy drinks can increase your risk
- Being honest and reporting symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint

### **What should I do if I think I am developing warning signs that may lead to sudden cardiac arrest?**

1. *Tell an adult – your parent or guardian, your coach, your athletic trainer or your school nurse*
2. *Get checked out by your health care provider*
3. *Take care of your heart*
4. *Remember that the most dangerous thing you can do is to do nothing*

# **SUDDEN CARDIAC ARREST**

## *A Fact Sheet for Parents*

---

### **FACTS**

Sudden cardiac arrest is a rare, but tragic event that claims the lives of approximately 500 athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences an illness which has caused an inflammation to the heart or after a direct blow to the chest.

### **WARNING SIGNS**

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Warning signs can include a complaint of:

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### **EMERGENCY SIGNS – Call EMS (911)**

If a person experiences any of the following signs, call EMS (911) immediately:

- *If an athlete collapses suddenly during competition*
- *If a blow to the chest from a ball, puck or another player precedes an athlete's complaints of any of the warning signs of sudden cardiac arrest*
- *If an athlete does not look or feel right and you are just not sure*

### **How can I help my child prevent a sudden cardiac arrest?**

Daily physical activity, proper nutrition, and adequate sleep are all important aspects of life-long health. Additionally, parents can assist student athletes prevent a sudden cardiac arrest by:

- Ensuring your child knows about any family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age)
- Ensuring your child has a thorough pre-season screening exam prior to participation in an organized athletic activity
- Asking if your school and the site of competition has an automatic defibrillator (AED) that is close by and properly maintained
- Learning CPR yourself
- Ensuring your child is not using any non-prescribed stimulants or performance enhancing drugs
- Being aware that the inappropriate use of prescription medications or energy drinks can increase risk
- Encouraging your child to be honest and report symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint

### **What should I do if I think my child has warning signs that may lead to sudden cardiac arrest?**

1. *Tell your child's coach about any previous events or family history*
2. *Keep your child out of play*
3. *Seek medical attention right away*



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## ATHLETIC DEPARTMENT DRUG TEST CONSENT FORM

I have received, read, and understand a copy of the "Wawasee Drug Testing Policy for Athletes." I desire that the student identified below participate in this program, and hereby, voluntarily agree to be subject to its terms for the entire upcoming school year from the signed date below. I accept the method of obtaining specimens, testing, and analyses of such specimen, and all other aspects of the program.

I agree to cooperate in furnishing specimens that may be required whenever the student's name list is randomly drawn. I also understand that unless I provide just cause otherwise, that positive results obtained through such testing may lead to disciplinary measure taken against the student listed as outlined in the Wawasee High School Student Handbook.

I further agree and consent to the disclosure of the sampling, testing, and results provided by this testing program to the people designated in the same testing policy. The consent is given pursuant to all State and Federal Privacy Statutes, and is a waiver of rights to nondisclosure of such test records and results only to the extent of the disclosures in the program.

Athlete's PRINTED Name: \_\_\_\_\_

Date: \_\_\_\_\_, 20\_\_\_\_

School Year: 20\_\_\_\_ - 20\_\_\_\_

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Parent/Guardian Signature

-----  
I, (athlete listed above), have decided to **NOT** participate in Wawasee High School sponsored sports for the remainder of the school year listed above. I understand that in order for me to participate in a sport at a later date that I must sign-off on a similar waiver and be willing to submit to a specimen and follow the Testing Policy for Athletes.

\_\_\_\_\_  
Athlete's Signature

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Cory Schutz  
Athletic Director

Brent Doty  
Assistant Athletic Director

Andrew Wilson  
Administrative Assistant



CONCUSSION and SUDDEN CARDIAC ARREST  
ACKNOWLEDGEMENT AND SIGNATURE FORM  
FOR PARENTS AND STUDENT ATHLETES

Student Athlete's Name (Please Print): \_\_\_\_\_

Sport Participating In (If Known): \_\_\_\_\_ Date: \_\_\_\_\_

IC 20-34-7 and IC 20-34-8 require schools to distribute information sheets to inform and educate student athletes and their parents on the nature and risk of concussion, head injury and sudden cardiac arrest to student athletes, including the risks of continuing to play after concussion or head injury. These laws require that each year, before beginning practice for an interscholastic or intramural sport, a student athlete and the student athlete's parents must be given an information sheet, and both must sign and return a form acknowledging receipt of the information to the student athlete's coach.

IC 20-34-7 states that a high school athlete who is suspected of sustaining a concussion or head injury in a practice or game, shall be removed from play at the time of injury and may not return to play until the student athlete has received a written clearance from a licensed health care provider trained in the evaluation and management of concussions and head injuries.

IC 20-34-8 states that a student athlete who is suspected of experiencing symptoms of sudden cardiac arrest shall be removed from play and may not return to play until the coach has received verbal permission from a parent or legal guardian of the student athlete to return to play. Within twenty-four hours, this verbal permission must be replaced by a written statement from the parent or guardian.

Parent/Guardian - please read the attached fact sheets regarding concussion and sudden cardiac arrest and ensure that your student athlete has also received and read these fact sheets. After reading these fact sheets, please ensure that you and your student athlete sign this form, and have your student athlete return this form to his/her coach.

---

As a student athlete, I have received and read both of the fact sheets regarding concussion and sudden cardiac arrest. I understand the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury, and the symptoms of sudden cardiac arrest.

\_\_\_\_\_  
(Signature of Student Athlete)

\_\_\_\_\_  
(Date)

I, as the parent or legal guardian of the above named student, have received and read both of the fact sheets regarding concussion and sudden cardiac arrest. I understand the nature and risk of concussion and head injury to student athletes, including the risks of continuing to play after concussion or head injury, and the symptoms of sudden cardiac arrest.

\_\_\_\_\_  
(Signature of Parent or Guardian)

\_\_\_\_\_  
(Date)





**WAWASEE HIGH SCHOOL**  
**Athletic Responsibility Acknowledgment**  
**DEPARTMENT OF ATHLETICS**

\_\_\_\_\_  
Athlete's Name

\_\_\_\_\_  
Grade

\_\_\_\_\_  
School Year

Prior to participating in any practice or tryouts sessions for any interscholastic sport, each athlete must:

PLEASE SELECT ONE:

I Would like to be contacted about Hoosier Healthwise & HIP Insurance

I Opt NOT to be contacted

- Successfully pass a physical examination by a registered physician and the copy of such examination must be on file in the office of the Athletic Director. One current physical examination per year is sufficient for all sports during that school year.
- Return to his/her coach the Athletic Responsibility Acknowledgment Form -- properly signed.
- Return to his/her coach the Emergency Medical Card -- properly filled out and signed.
- Return to his/her coach the Extra Curricular Activities/Student Driving Drug Testing Policy -- properly signed.
- Return to his/her coach the Concussion Information and Signature Form -- Read Fact Sheet and properly sign Form.

**ATHLETIC RESPONSIBILITY ACKNOWLEDGEMENT**

As a Wawasee High School student athlete participating voluntarily in interscholastic athletics, I understand that:

1. I will abide by the Wawasee High School Student Code of Conduct, the School's Handbook, the coaches' team rules and the rules of the Indiana High School Athletic Association.
2. I know that athletic participation is a privilege. I will conduct myself in an exemplary social manner at all times.
3. I will be responsible for all athletic equipment issued to me throughout the season, will return such equipment at the conclusion of the season, and will pay the current replacement cost for any of the equipment not accounted by me at the end of the season.
4. I will not use or be in possession of tobacco, alcohol or narcotics. If I do use any of these substances, am in possession of such substances, or am suspended from school for use or possession of these substances, I will be subject to disciplinary actions as outlined in the student handbook.
5. I acknowledge that I have been properly advised, cautioned and warned by administrative and coaching personnel of Wawasee High School that I am exposing myself to the risk of injury, including but not limited to, the risk of sprains, fractures and ligament and/or cartilage damage which could result in a temporary or permanent, partial or complete impairment in the use of my limbs, brain damage, paralysis, or even death. Having been so cautioned and warned, it is still my desire to participate in sports and to do so with full knowledge and understanding of the risk of injury.
6. I understand that there is a risk of injury involved in athletics and agree to accept the financial responsibility of any such injuries. I agree to release and hold harmless my school from all responsibility and liability from any injury or claim.
7. I, along with my parent, certify that I have read and understand the Wawasee High School Athletic Policies in the school's handbook and in order to be eligible for participation, I must comply with all requirements listed.
8. I will complete my Emergency Medical Card information and sign the Use and Disclosure of Protected Health Information statement. My treating physician is authorized to disclose information regarding any injury I may receive during the course of the season, as well as my general fitness to play, to my coach or any designated member of the coaching staff.

STUDENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_

PARENT SIGNATURE \_\_\_\_\_

DATE \_\_\_\_\_



# Wawasee High School

## EMERGENCY INFORMATION CARD

The athletic department is seeking your permission to have your son or daughter treated in a doctor's office or a hospital emergency room in the event that he or she is found in need of emergency medical treatment. If an emergency occurs, every effort will be made to contact you. If such a contact is not possible, this card may facilitate prompt treatment. I hereby give permission for my child to receive emergency medical treatment.

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Student Name (print) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Phone # \_\_\_\_\_ Add'l Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Phone # \_\_\_\_\_ Add'l Phone # \_\_\_\_\_

Step Parent/Guardian \_\_\_\_\_ Work Phone # \_\_\_\_\_ Add'l Phone # \_\_\_\_\_

Alternate Person \_\_\_\_\_ Phone # \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Allergies/Medical Conditions \_\_\_\_\_

Medications \_\_\_\_\_

*\*\* Please list any additional information on back*

Sports \_\_\_\_\_





***Parkview Sports Medicine***

**Consent to Treat**

I hereby authorize medical treatment for said athlete at \_\_\_\_\_ (School Name) by the athletic trainers, physicians, and staff of Parkview Ortho Performance Center d/b/a Parkview Sports Medicine. A family member can be reached at \_\_\_\_\_ in the event additional treatment or information is required. I understand that if the said athlete is seen by a physician or other provider at Parkview Sports Medicine and my insurance requires prior approval, I will be responsible for notifying the appropriate party in order to obtain approval.

Student Name _____	Student Signature _____
Mailing Address _____	City/State/Zip _____
Date _____	Student Date of Birth _____
Parent/Guardian Name _____	Parent/Guardian Signature _____

\*\*\*\*\*

**Acknowledgement of Receipt or Declination of Notice of Privacy Practices**

I acknowledge that Parkview Ortho Performance Center d/b/a Parkview Sports Medicine (PSM) has offered me a copy of its Notice of Privacy Practices. The Notice describes how Parkview may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights that I have regarding my health information. I understand that I should read it carefully. By signing this Acknowledgement, I acknowledge that I have received a copy of the Notice.

The Notice of Privacy Practices is also available at the front desk at all PSM offices and on the PSM web site at [www.parkviewsportsmedicine.com](http://www.parkviewsportsmedicine.com). Parkview reserves the right to change the Notice at any time. I understand that I can obtain any revisions to the Notice by accessing the PSM web site, calling PSM and requesting a copy of the Notice be mailed to me or asking for one at the time of my next appointment.

Student Name _____	Student Signature _____
Parent/Guardian Name _____	Parent/Guardian Signature _____
Date _____	





## ***Parkview Sports Medicine***

### **Authorization for Release of Medical Information**

I hereby authorize Parkview Ortho Performance Center d/b/a Parkview Sports Medicine, its physicians and providers ("PSM") to release any and all information regarding medical treatment provided to \_\_\_\_\_ (Student Name) related to any injury, illness or that otherwise concerns my physical condition and ability to participate in athletics at \_\_\_\_\_ (School Name). PSM may disclose the information to the School, its administration, coaching and athletic staff for the purpose of informing them of my playing status. I expressly authorize PSM to discuss my condition with these individuals.

If I am over 18: I also authorize PSM to release my medical information to my parent(s)/guardian(s).

I understand that I may revoke this authorization at any time by notifying PSM, in writing, of the revocation. The revocation will not affect any action already taken in reliance on this authorization. If not previously revoked, this authorization will terminate one (1) year from the earliest date set forth below.

I understand that information disclosed to the School, its administration, coaching and athletic staff pursuant to this authorization may be re-disclosed and no longer protected by federal privacy laws. PSM will not be responsible for any such further use or disclosure of the information.

I understand that PSM will not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization.

A photocopy of this authorization shall be considered as valid as the original.

Student Name \_\_\_\_\_ Student Signature \_\_\_\_\_

Student Address \_\_\_\_\_

Date \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

Relationship to the Student \_\_\_\_\_

Date \_\_\_\_\_

**You Are Entitled To A Copy Of This Authorization**







***Parkview Sports Medicine***

**Interview/Photographic Release**

I hereby authorize Parkview Ortho Performance Center d/b/a Parkview Sports Medicine and its employees to interview, photograph and videotape \_\_\_\_\_ (Name of Athlete) while participating in athletic events, practices and other functions associated with athletics at the above identified School. I understand that the Athlete's likeness and name may be used and displayed by Parkview Sports Medicine on its website and on social media, such as Twitter. I understand that if the Athlete provides an interview, information provided in the interview may also be included on the Parkview Sports Medicine website or on social media. I hereby release Parkview Sports Medicine, its employees and affiliates from any and all liability, claims, demands and causes of action connected with the use and publication of the Athlete's likeness and other identifying information on the Parkview Sports Medicine website and social media.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

