Port Washington High School

Sports Medicine Emergency Information and Consent

Student's Name:_________________________________ Date of Birth: ____________________
Parent/Guardian 1 Name: __________________________ Phone: ________________________
Address: ____
Parent/Guardian 2 Name: __________________________ Phone: ________________________
Address: ____
Alternate Emergency Contact Name: ______________________ Relationship: ______________
Address: ____ Phone: ________________

IN CASE OF EMERGENCY, PLEASE NOTIFY:

First, Try: ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Alternate Emergency Contact
Then, Try: ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Alternate Emergency Contact
Then, Try: ☐ Parent/Guardian 1 ☐ Parent/Guardian 2 ☐ Alternate Emergency Contact

STUDENT'S MEDICAL INFORMATION

Primary Doctor: ______________________________________ Phone: ____________________
Current Medications: ____
Known Allergies: ____
Other Medical Conditions: (asthma, diabetes, previous head injuries, etc. Use back of sheet if needed) __________
____
____ ☐ (continued on back)
Name of Medical Insurance Company or Plan: ______________________________________
Policy Number: __________________________ Is plan an HMO? ☐ Yes ☐ No
If plan is an HMO, what is your primary care facility? ______________________________

MEDICAL CONSENT TO TREAT STUDENT; AUTHORIZATION TO DISCLOSE STUDENT'S MEDICAL INFORMATION

Consent may be required in order for Student to participate in an athletic program. Consent is effective until it is revoked by a parent or guardian, or until Student is no longer enrolled at the School.
If no box is checked, it is assumed that consent is NOT given. Please check all applicable.

☐ **Yes** ☐ **No** The athletic staff, including athletic trainers, coaches, or other qualified personnel may apply first aid treatment for any injury sustained during participation in athletic programs sanctioned by School.

☐ **Yes** ☐ **No** The athletic trainer may evaluate and treat other emergent or non-emergent Student injuries or medical conditions brought to the athletic trainer's attention as they relate to the Student's physical activity, conditioning or injury prevention.

☐ **Yes** ☐ **No** If the athletic staff determines that Student is in need of immediate medical attention beyond that which can be provided by the athletic staff at School and the Student's parent, guardian, or emergency contact cannot be reached, the athletic staff may use their judgment in securing medical aid, including ambulance service and admittance to a hospital if needed.

☐ **Yes** ☐ **No** If available at School, School's athletic trainer may provide appropriate treatment modalities, such as ultrasound and electronic stimulations to treat any Student injury or other medical condition.

Parent/Guardian Signature: ______________________________ Date: ______________
☐ Parent 1 ☐ Parent 2 ☐ Guardian (relationship) ____________

Student Signature: ____________________________________ Date: ______________

Port Washington High School

AUTHORIZATION TO DISCLOSE STUDENT'S MEDICAL INFORMATION

If this document is not signed, it is assumed that authorization is **NOT** given. Authorization is effective until it is revoked by a parent or guardian, or until Student is no longer enrolled at the School.

Student's Name: ______________________ Date of Birth: ______________________

The purpose of this authorization is to permit disclosure of Student's protected health information (PHI) among health care professionals, coaches, athletic training staff, insurance personnel, and academic counselors and administrators. This disclosure allows athletic medical staff and School to make certain decisions about Student's health and ability to participate in certain athletic programs sanctioned by School in accordance with the Health Information Portability and Accountability Act (HIPAA). HIPAA protects personal injury and illness information from disclosure without authorization under HIPAA. Student's PHI includes, but is not limited to, information involving the nature and treatment of an injury or illness, medical history and status, prognosis, diagnosis, athletic participation status, insurance coverage, and copies of hospital and medical records.

Pursuant to this signed authorization, athletic training staff, including trainers, coaches, or other qualified personnel of Port Washington High School (School) are authorized to disclose Student's PHI verbally or in writing, as necessary and appropriate for the purpose of health care treatment or exchanging information regarding Student's health as permitted or required under the law (e.g. determining Student's ability and eligibility to participate in athletic programs sanctioned by School, evaluating injuries and other medical conditions which Student reports while engaging in athletic programs sanctioned by School, etc.).

The Student's PHI may be disclosed to:

(1) School's coaches, athletic director, or other members of School's administrative staff or their designees;
(2) Student's parents and guardians; and
(3) Emergency medical personnel, hospitals, or other health care professionals who evaluate, diagnose or treat an injury, illness, or other condition incurred by Student while participating in athletic programs sanctioned by School, as necessary to:
   (a) Evaluate Student's eligibility to participate in School activities, including but not limited to interscholastic or intramural sports programs and physical education classes;
   (b) Document and evaluate first aid treatment and athletic treatment modalities provided;
   (c) Evaluate treatment alternatives; and
   (d) Resolve disputes that arise with regard to the above.

Signing this authorization/consent is voluntary, and authorization may be revoked at any time by a written revocation sent to both School's athletic department and athletic training staff. However, authorization may be required in order for Student to participate in an athletic program. Any revocation will not apply to information that has already been released. Student and Student's parents and guardians reserve the right to review all records and to obtain a copy of all records released at any time upon request. In the event that Student's PHI is re-disclosed by a person who receives it under this authorization, it will no longer be covered by this authorization.

Parent Signature: ______________________ Date: ____________
Parent Name: ______________________

Student Signature: ______________________ Date: ____________