

STEADMAN HAWKINS SPORTS MEDICINE SERVICES
CONSENT AND AUTHORIZATION

I, _____, parent/legal guardian of _____, a student/participant at _____ (the "School/Event") authorize Greenville Hospital System ("GHS") staff to provide my child any healthcare services offered by Steadman Hawkins Sports Medicine ("SHSM") and to make appropriate referrals for my child to receive any additional health services that my child's condition may indicate. To protect and improve the health of athletes, GHS will provide athletic trainers to provide on-site treatment and consultation to student/participants. These services will be overseen by a physician serving as Medical Director for SHSM.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff of SHSM to arrange for such care, including appropriate transportation. I understand that SHSM staff will contact me as soon as possible in the event my child has an urgent or emergency condition. I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the SHSM program. I understand that I may contact the Athletic Trainer assigned to the School or the Medical Director for SHSM to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by GHS/SHSM staff of information about my child's medical condition obtained through SHSM Services to physicians, coaches, and other employees or agents of GHS or to whom I am referred. I also consent to the release of information about my child's medical condition to necessary staff at the school, should accommodations be needed to aid in my child's education.

I understand that I will not be charged for services rendered on-site by the medical staff, but that I or my child's insurance carrier may be charged for services rendered by other healthcare providers. I consent for information in my child's medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize GHS to submit claims for services rendered to my child and assign to GHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by SHSM, I hereby release Greenville Hospital System, its trustees, officers, employees, and agents from and against any claim, liability, and cause of action or other expense arising out of the services provided by GHS Sports Medicine Services.

I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

I have read and understand the above information and consent to my child's participation in GHS Sports Medicine Services.

Name of Parent/Guardian (please print)

Signature of Parent/Guardian

Name of Student (First, Middle, Last)

Witness/Date

STEADMAN HAWKINS SPORTS MEDICINE

Athlete's Name _____ DOB _____ Grade _____
(First / Middle / Last)

School _____ Sport(s) _____

Guardian(s) _____ Phone #'s (h) _____ (c) _____
Relationship(s) _____

Address _____
Street City State Zip

Guardian(s) Email _____ Student Athlete's Email _____
(For SHSM Emails of Athletic Training/Conditioning Topics)

Emergency contact _____ Phone #'s (h) _____ (c) _____
(Guardians will be contacted first in case of emergency, please list individual other than listed above)

Ins. Carrier _____ HMO/PPO Group/Policy# _____
(circle one)

Insurance Preferred Network/Provider: **yes/no** (circle one) Whom _____

| Does your child have any of the following? (List details as appropriate) | Yes | No |
|--|--------------------------|--------------------------|
| Asthma _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Inhaler _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart condition _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Vision loss _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney condition _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Hearing loss _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergies _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Medication Allergy _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Severe headaches _____ | <input type="checkbox"/> | <input type="checkbox"/> |

Previous injuries/surgeries (month/year) _____

Is your child on any medication that is taken on a regular basis? (List) _____

Does your family have a primary care physician? (Name & phone #) _____

Does your family have an orthopaedic doctor? (Name & phone #) _____

My child may take any over-the-counter medication such as Tylenol®/Advil® YES NO

Parent/Guardian Signature

Date

PRE-PARTICIPATION HISTORY & PHYSICAL EXAM

Name: _____ Sex: F M Age: _____ Date of Birth: _____
 Grade: _____ School: _____ Sport(s) Please list ALL: _____
 Address: _____ Phone: _____
 Personal Physician: _____ None
 Emergency Contact :Name: _____ Relationship: _____ Phone#(s): _____

Attention parent or guardian and athlete: answers to the following questions are very important!!! Please take the time, read through the questions, and answer to the best of your knowledge.

General Medical History:

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Do you have asthma? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you have diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have seizures? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have sickle cell trait? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have any other major medical problem? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been hospitalized or had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you cough, wheeze or have trouble breathing with exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you use an inhaler? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you have a single organ (testicle or kidney)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Are you currently taking any medicines or do you take any medicines on a regular basis (prescription or over-the-counter)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Have you ever taken any supplements or vitamins to help with weight loss, weight gain, or improve performance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Do you have any allergies (seasonal, insects, food, or medicines)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Have you ever had a rash or hives develop during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. Do you have any skin problems other than acne? | <input type="checkbox"/> | <input type="checkbox"/> |
| 16. Have you ever had a head injury, been knocked out, lost your memory, had your "bell rung," or a concussion? | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. Have you ever had numbness or tingling in your arms, hands, legs, or feet? | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Have you ever had a stinger, burner, or pinched nerve? | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Have you ever become ill from exercising in the heat? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Have you had mononucleosis or any significant illness in the last 60 days? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have trouble with your eyes/vision/ wear glasses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Do you have trouble with your hearing/wear hearing aid(s)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Do you want to weigh more or less than you do now? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. Do you lose weight regularly to meet weight requirements for your sport or other reason? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Do you feel stressed out, tired, or depressed? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Are there any other issues you would like to discuss with the doctor? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Are your immunizations up to date? | <input type="checkbox"/> | <input type="checkbox"/> |

FEMALES ONLY

- | | | |
|---|--------------------------|--------------------------|
| 27. Are your periods regular (every month)? | <input type="checkbox"/> | <input type="checkbox"/> |
| 28. Are your periods heavy? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here (use back/page 2 if needed): _____

Cardiac History:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever passed out during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever been dizzy during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you ever had chest pain or chest pressure during or after exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you tire easily or more quickly than your friends during exercise? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever had racing of your heart or skipped heartbeats? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you ever been told you had a heart murmur? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever been told you had an enlarged or weak heart? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Has any member of your family: -died of heart problems or sudden death before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| -been told they had a serious heart problem before age 50? | <input type="checkbox"/> | <input type="checkbox"/> |
| -been told they had Marfan's syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Has a physician ever denied or restricted your participation in sports? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here: _____

Orthopaedic History:

- | | YES | NO |
|---|--------------------------|--------------------------|
| 1. Have you ever broken or fractured any bones? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you ever subluxed or dislocated any joint? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had any other problems related to your: -neck, spine, or back? | <input type="checkbox"/> | <input type="checkbox"/> |
| -shoulders? | <input type="checkbox"/> | <input type="checkbox"/> |
| -elbows? | <input type="checkbox"/> | <input type="checkbox"/> |
| -wrists, hands, or fingers? | <input type="checkbox"/> | <input type="checkbox"/> |
| -hips? | <input type="checkbox"/> | <input type="checkbox"/> |
| -knees? | <input type="checkbox"/> | <input type="checkbox"/> |
| -ankles, feet, or toes? | <input type="checkbox"/> | <input type="checkbox"/> |
| -other? | <input type="checkbox"/> | <input type="checkbox"/> |

Explain "YES" answers here (put date of injury if known): _____

Parent's Permission & Acknowledgement of Risk for Son or Daughter to Participate in Athletics

As the parent or legal guardian of the above named student-athlete, I give my permission for his/her participation in athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information or by some other means. My signature indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

Signature of athlete _____ Date _____

Signature of parent/guardian _____ Date _____

PRE-PARTICIPATION SPORTS PHYSICAL EXAM

Vision: L20/____ R20/____ Both _____ Corrected: Y N BMI _____ (Wt in kg/ hgt in meters squared)

Height _____ Weight _____ Pulse _____ B/P (R arm) _____

| Medical | Normal | Abnormal Findings |
|--|--------|-------------------|
| Appearance/Emotional Affect | | |
| Head/Eyes/Ears/Nose/Throat | | |
| Lymph Nodes | | |
| Heart (squatting to standing and supine) | | |
| Pulses (include femoral) | | |
| Lungs | | |
| Abdomen | | |
| Genitalia (males only) | | |
| Skin | | |
| Musculoskeletal | Normal | Abnormal Findings |
| Neck | | |
| Back | | |
| Shoulder/Arm | | |
| Elbow/Forearm | | |
| Wrist/Hand | | |
| Hip/Thigh | | |
| Knee | | |
| Leg/Ankle | | |
| Foot | | |

May Participate in all sports, **EXCEPT** those listed below:

May Participate after completing evaluation/rehabilitation for: _____

May Not Participate – Reason: _____

Recommendations: _____

Signature of M.D. _____ **Date of Exam:** _____

Printed Name: _____ **Office Stamp**

Phone Number: _____

Extra Space for "YES" answers from the front: _____

Developed 2003-2004 by the Richland County (South Carolina) School District One Task Force On Athletic Health Issues following a review of related information from the American Academy of Family Physicians, American Academy of Pediatrics, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, American Osteopathic Academy of Sports Medicine, the South Carolina High School League and the National Federation of State High School Associations. Revised 011807 by the SCMA Medical Aspects of Sports Committee