Authorization for Sports Medicine Services and Consent for Treatment

I, the undersigned, am the parent/legal guardian of, ________________________________, a student-athlete at Bishop Fenwick High School who plans on participating in ______________________. I understand that Bishop Fenwick High School will provide a board certified licensed Athletic Trainer to be present during sporting events and after school. This enables Bishop Fenwick High School to provide Athletic Training services at the school for all student-athletes including the above mentioned which are governed and covered under state and national scope of practice and under MIAA guidelines. Sports medicine services may include but are not limited to: administrating first-aid, providing initial injury assessments and subsequent treatment, and management of acute injuries to all student-athletes, coaches, or parents/guardians present at sporting events. I understand that any duties performed or conducted to any and all student-athletes, or staff members employed by the school will be documented and confidentially filed either by the School Nurse, Athletic Trainer, or both. I understand that there is no charge to me for the above listed Athletic Training services provided and if further treatment by a physician or if rehabilitation services for the injury are needed, he or she may see the health care provider of his/her choice.

I hereby authorize the Athletic Trainer and/or Nurse to disclose pertinent information about the athlete's injury status. I fully understand such disclosures will be at the discretion of the Medical staff at Bishop Fenwick and parties involved can be but are not limited to coaching staff, Athletic Director, school nurse, and treating healthcare provider and/or concussion management specialist.

Injured athletes that have been evaluated and/or treated by a physician **must submit** written clearance from that physician signed and dated to the Athletic Trainer, Nurse, or both **prior** to the above mentioned student-athlete being permitted to resume in any school related activity or function. In circumstances where an athlete has been removed from play because of a suspected head injury or if a concussion is suspected by the Bishop Fenwick Medical staff, the athlete will not be permitted to return to play or participate in any school sanctioned function deemed physically taxing by Bishop Fenwick school medical staff until they are evaluated by the appropriate healthcare provider and have received medical clearance in the form of written authorization from that provider. I also understand that it is the discretion of the Bishop Fenwick and associated medical staff to perform further return to play progressions and testing after medical clearance is obtained before the student-athlete can return to practice or competition to further ensure safe re-entry into the sport of the above mentioned student-athlete. Return to play guidelines meet and fall under all state, national, and MIAA scope of practice requirements and guidelines and are incompliance with all currently active sport research and medical studies.

All athletes must have health insurance coverage to participate in sports/sports related activities.

Parent/Guardian Name: _____________________________ Signature: ________________Date:________
Relationship to student-athlete: __________________Cell Phone: ____________Work:_______________
Home Address: ____Home Phone:_________________
Student-Athlete Name: _________________________________Sex:_______ Grade: _____DOB:________
Current Allergies:____
Current Medications (i.e. asthma inhalers, epi-pen, etc)_______________________________________
____
____
Physical impairments:____
Other pertinent medical history (surgeries, diabetes, disorders, seizures, heart condition, etc):
____
____
____
Primary Care Provider: ________________________________Phone number: ______________________
Health Insurance Co____________________ Policy No_____________ Policyholder__________________

Pre-Participation Head Injury/Concussion Reporting:

Has the student-athlete ever experienced a traumatic head injury (a blow to the head)? Yes____ No____
If yes, when? Dates: ________________
Has student ever received medical attention for a head injury? Yes____ No____ If yes, when?
Dates: __________________________If yes, please describe the circumstances:
____
____
____
____

Has the student-athlete ever been diagnosed by a medical professional (Physician, Athletic Trainer, EMS, etc) with a concussion? Yes____ No____
If yes, when? Dates/Amount of time out:
____ ____
____ ____

Duration of symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion: __________

Student Athlete Signature: _______________________________________ Date: __________

Parent/Guardian Signature: _______________________________________Date: __________

Statement Acknowledging Receipt of Education and Responsibility to Report Signs/Symptoms of Concussion:

I, ___________________________, a prospective student-athlete at Bishop Fenwick High School herby acknowledge my responsibility to report any and all signs/symptoms of a concussion to my school's Athletic Trainer, Coaches and parent(s)/guardian(s). I also acknowledge that by not communicating symptoms such as these puts myself in a dangerous circumstance in which I run the risk or further injury, prolonged time out, and the possibility of loss of life due to second impact syndrome.

____ ____

Student Athlete Signature Date

I, the parent/guardian of the above mentioned student-athlete, herby acknowledge having received education about the signs/symptoms and risks of sport related concussion acknowledge my responsibility to report preferably in writing to Bishop Fenwick's Athletic Trainer, Nurse, or coaches any signs/symptoms of a concussion in the above minor. I realize that lack to do so puts the above mentioned student-athlete in a position to further increase injury, increased time out, and risk the possibility of loss of life due to second impact syndrome.

____ ____

Parent/Guardian Signature Date

Dispensing Over The Counter Medicine Consent:

Advil/Ibuprofen (NSAIDS): Yes_______ No_______

TUMS (Antacids): Yes_______ No_______

Medi-Lyte (Electrolyte Replenisher) Yes________ No ________

Topical Pain Relief Analgesic Creams (Bio-freeze, Icy Hot, Red Hot, Pain-stop, etc): Yes________ No________

____ ____

Parent/Guardian Signature Date