



HENRY FORD ALLEGIANCE HEALTH

CONSENT FOR SPORTS PHYSICAL AND AUTHORIZATION FOR RELEASE OF INFORMATION

Student-Athlete Name: _____ (Please Print)

School: _____

CONSENT. I hereby grant permission to W.A. Foote Memorial Hospital d/b/a Henry Ford Allegiance Health ("HFAH") to render to myself/my child a sports physical screening exam. I understand that this is a sports physical screening exam and that it is not a comprehensive exam and is not intended to provide treatment nor to create a physician/patient relationship. I understand that athletic participation comes with the risk of injury. This physical exam cannot detect all problems or prevent injury from athletic participation. I understand that if follow-up evaluation is recommended, it is my responsibility to seek care from an appropriate provider.

AUTHORIZATION FOR RELEASE OF INFORMATION. I hereby authorize the disclosure of my/my child's individually identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Persons/organizations authorized to release student-athlete's individually identifiable health information include the following: The above referenced School (hereinafter "School") Athletic Trainer(s), Team Physician(s)/Consultant(s), and HFAH.

Person/organizations authorized to receive student-athlete's individually identified health information include the following: School Trainer(s), Team Physician/Consultant(s), HFAH, parents/guardians of the above referenced student-athlete, School coaches, and representatives of School's administration.

Description of information to be disclosed: All information relating to and including all injuries, illnesses and/or conditions of the student-athlete and any and all related medical information that may have resulted from, or may be connected with, the student-athlete's sports physical.

Reasons for disclosure: To communicate information about the student-athlete between School Athletic Trainer(s), Team Physician(s)/Consultant(s), and HFAH about the student-athlete's health status and injury/illness as determined by a sports physical exam. Further, to notify, inform, and advise the student-athlete's parents/guardians, School coaches, and School administration about the status of the student-athlete's physical condition(s) as determined by a sports physical.

I have read and understand the following statements:

- I may revoke this authorization at any time prior to its expiration date by providing written notification. However, I understand that revocation will not apply to information that has already been disclosed in response to this authorization.
Upon request, I may see and copy the information described on this form.
I understand that information used or disclosed as the result of this authorization and release may be re-disclosed by the person/entity receiving the information.
This authorization will expire one (1) year after the date of signature.

Privacy Notice Acknowledgement: I acknowledge that a copy of the Privacy Notice was made available to me.

I declare that I have read, understand, and agree to the contents of this Consent for Treatment and Authorization for Release of Injury or Illness Information in its entirety.

Signature of Student-Athlete _____ Date: _____

Signature of Parent/Guardian _____ Date: _____

*Parent/Guardian signature required if Student-Athlete is under 18 years of age.

Relationship to Student-Athlete: _____



MEDICAL HISTORY: Completed by Parent or Guardian of 18-year-old

Student Name: _____ Date of Exam: _____

Family Doctor: _____ Phone: _____

GENERAL QUESTIONS: Has a doctor ever denied or restricted your participation in sports for any reason? Do you have any ongoing medical conditions? HEART HEALTH QUESTIONS ABOUT YOU: Have you ever passed out or nearly passed out DURING or AFTER exercise? HEART HEALTH QUESTIONS ABOUT YOUR FAMILY: Has anyone in your family had unexplained fainting, unexplained seizures or near drowning? BONE AND JOINT QUESTIONS: Have you ever had an injury to a bone, muscle, ligament or tendon that caused you to miss a practice or a game?

MEDICAL QUESTIONS: Do you cough, wheeze or have difficulty breathing during or after exercise? Have you ever used an inhaler or taken asthma medicine? Is there anyone in your family who has asthma? Were you born without, or missing a kidney, eye, testicle (males), spleen or any other organ? Do you have groin pain or a painful bulge or hernia in the groin area? Do you have infectious mononucleosis (mono) within the last month? Do you have any rashes, pressure sores or other skin problems? Do you have a herpes or MRSA skin infection? Do you have headaches or get frequent muscle cramps when exercising? Have you ever become ill while exercising in the heat? Do you or someone in your family have sickle cell trait or disease? Have you had any problems with your eyes or vision or any eye injuries? Do you wear glasses or contact lenses? Do you wear protective eyewear such as goggles or a face shield? Immunization History: Are you missing any recommended vaccines? Do you have any allergies? Have you ever had a head injury or concussion? Do you have any concerns that you would like to discuss with a doctor? Have you ever received a blow to the head that caused confusion, prolonged headache or memory problems? Have you ever had numbness, tingling, weakness or inability to move your arms or legs after being hit or falling? Have you ever had an eating disorder? Do you worry about your weight? Are you trying to or has anyone recommended that you gain or lose weight? Are you on a special diet or do you avoid certain types of foods? FEMALES ONLY (Optional): Have you ever had a menstrual period? How old were you when you had your first menstrual period? How many periods have you had in the last 12 months? CURRENT-YEAR PHYSICAL - GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

PHYSICAL EXAMINATION & MEDICAL CLEARANCE: Completed by MD, DO, PA or NP - RETURN DIRECTLY TO PATIENT

EXAMINATION: Height: _____ Weight: _____ [] Male [] Female BP: _____ / _____ Pulse: _____ Vision: R 20/ _____ L 20/ _____ Corrected: [] Y [] N

Table with columns: MEDICAL, NORMAL, ABNORMAL, MUSCULOSKELETAL, NORMAL, ABNORMAL. Rows include: Appearance: Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency), Neck; Eyes/Ears/Nose/Throat: Pupils Equal, Hearing, Back; Lymph nodes, Shoulder/Arm; Heart: Murmurs (auscultation standing, supine, +/- Valsalva) Location of point of maximal impulse (PMI), Elbow/Forearm; Pulses: Simultaneous femoral and radial pulses, Wrist/Hand/Fingers; Lungs, Hip/Thigh; Abdomen, Knee; Genitourinary (males only), Leg/Ankle; Skin: HSV: Lesions suggestive of MRSA, linea corporis, Foot/Toes; Neurologic, Functional Duck Walk

RECOMMENDATIONS:

I certify that I have examined the above student and recommend him/her as being able to compete in supervised athletic activities NOT crossed out below. BASEBALL - BASKETBALL - BOWLING - COMPETITIVE CHEER - CROSS COUNTRY - FOOTBALL - GOLF - GYMNASTICS - ICE HOCKEY LACROSSE - SKIING - SOCCER - SOFTBALL - SWIMMING/DIVING - TENNIS - TRACK & FIELD - VOLLEYBALL - WRESTLING

EXAMINER [Arrow] Name of Examiner (print/type): _____ Date: _____ Signature of Examiner: _____ (Check One): [] MD [] DO [] PA [] NP

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

EMERGENCY INFORMATION COMPLETED BY PARENT OR GUARDIAN OF 18-YEAR-OLD

Student: _____ Grade: _____ Doctor: _____ Phone: (____) _____ IN EMERGENCY (1): _____ Home #: (____) _____ Cell #: (____) _____ IN EMERGENCY (2): _____ Home #: (____) _____ Cell #: (____) _____ Drug Reactions: _____ Current Medications: _____ Allergies: _____



PRE-PARTICIPATION PHYSICAL - CONSENT - INSURANCE

Shaded headline areas are to be completed by student, parent/guardian or 18-year-old

There are FOUR (4) signatures on this page **4** to be completed by student, parent/guardian and/or 18-year-old

A CURRENT-YEAR PHYSICAL IS ONE GIVEN ON OR AFTER APRIL 15 OF THE PREVIOUS SCHOOL YEAR

Student Name: _____
LAST FIRST MIDDLE INITIAL

Student Address: _____
STREET CITY ZIP

Gender: M F Age: _____ Date of Birth: _____ Place of Birth (City/State): _____

School: _____ Circle Grade: 6 7 8 9 10 11 12

Father/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Mother/Guardian Name: _____

Phone (home): _____ (work): _____ (cell): _____

Email Address: Parent/Guardian/18-Year-Old: _____

STUDENT PARTICIPATION & PARENT or GUARDIAN or 18-YEAR-OLD CONSENT

The information submitted herein is truthful to the best of my knowledge. By my/my child's signature below, I/we acknowledge that I/we have received concussion educational information that meets Michigan Department of Health and Human Services and MHSAA requirements.

Further, in consideration of my/my child's participation in MHSAA-sponsored athletics, I/we do hereby agree, understand, appreciate, and acknowledge: that participation in such athletics is purely voluntary; that such activities involve physical exertion and contact and that there is inherent risk of personal injury associated with participation in such activities, which risk I/we assume; and that I/we agree to, and hereby waive any and all claims, suits, losses, actions, or causes of action against the MHSAA, its members, officers, representatives, committee members, employees, agents, attorneys, insurers, volunteers, and affiliates based on any injury to me, my child, or any person, whether because of inherent risk, accident, negligence, or otherwise, during or arising in any way from my/my child's participation in an MHSAA-sponsored sport.

I/we understand that I am/we are expected to adhere firmly to all established athletic policies of my school district and the MHSAA. I/we hereby give my consent for the above student to engage in interscholastic athletics and for the disclosure to the MHSAA of information otherwise protected by FERPA and HIPAA for the purpose of determining eligibility for interscholastic athletics. My child has my permission to accompany the team as a member on its out-of-town trips.

1 Signature of **STUDENT**: _____ Date: _____

2 Signature of **PARENT or GUARDIAN or 18-YEAR-OLD**: _____ Date: _____

INSURANCE STATEMENT

Our son/daughter will comply with the specific insurance regulations of the school district.

The student-athlete has health insurance: YES NO

If YES, Family Insurance Co: _____ Insurance ID #: _____

Additionally, I hereby state that, to the best of my knowledge, my answers to the medical history questions (see reverse) are complete and correct.

3 Signature of **PARENT or GUARDIAN or 18-YEAR-OLD**: _____ Date: _____

(DETACH HERE IF NEEDED TO ACCOMPANY STUDENT-ATHLETE)

MEDICAL TREATMENT CONSENT: COMPLETED BY PARENT or GUARDIAN or 18-YEAR-OLD

I, _____, an 18-year-old, or the parent or guardian of _____, recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary, and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then-existing circumstances and to assume the expenses of such care.

4 Signature of **PARENT or GUARDIAN or 18-YEAR-OLD**: _____ Date: _____