CONSENT FOR ATHLETIC PARTICIPATION & MEDICAL CARE

*Entire Page Completed By Patient

Athlete Information

Last Name_____ First Name _____ MI _____

Sex: [ ] Male [ ] Female Grade _____ Age _____ DOB ____/____/_____

Allergies _____

Medications_____

Insurance _____ Policy Number _____

Group Number _____ Insurance Phone Number _____

Emergency Contact Information

Home Address _____ (City) _____ (Zip) _____

Home Phone _____ Mother's Cell _____ Father's Cell _____

Mother's Name _____ Work Phone _____

Father's Name _____ Work Phone _____

Another Person to Contact _____

Phone Number _____ Relationship _____

Legal/Parent Consent

I/We hereby give consent for (**athlete's name**) _____ to represent (**name of school**) _____ in athletics realizing that such activity involves potential for injury. I/We acknowledge that even with the best coaching, the most advanced equipment, and strict observation of the rules, injuries are still possible. ***On rare occasions these injuries are severe and result in disability, paralysis, and even death. I/We further grant permission to the school and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical, or surgical care deemed reasonably necessary to the health and well being of the student athlete named above during or resulting from participation in athletics.*** By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal Guardian, ***I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student athlete.***

_____ _____ _____

Signature of Athlete **Signature of Parent/Guardian** **Date**

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another History Form.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, or other): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be placed into the athlete's medical file and should *not* be shared with schools or sports organizations. The Medical Eligibility Form is the only form that should be submitted to a school or sports organization.

Disclaimer: Athletes who have a current Preparticipation Physical Evaluation (per state and local guidance) on file should not need to complete another examination.

■ PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)
PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N		
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

■ PREPARTICIPATION PHYSICAL EVALUATION

MEDICAL ELIGIBILITY FORM

Name: _____ Date of birth: _____

☐ Medically eligible for all sports without restriction

☐ Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of

_____

_____

☐ Medically eligible for certain sports

_____

_____

☐ Not medically eligible pending further evaluation

☐ Not medically eligible for any sports

Recommendations: _____

_____

_____

I have examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

SHARED EMERGENCY INFORMATION

Allergies: _____

_____

_____

Medications: _____

_____

_____

Other information: _____

_____

_____

Emergency contacts: _____

_____

_____

WARNING, AGREEMENT TO OBEY INSTRUCTION,
RELEASE, ASSUMPTION OF RISK AND
AGREEMENT TO HOLD HARMLESS
(Both the applicant student and parent must read carefully and sign.)

STUDENT

I am aware that playing or practicing in any sport can be a dangerous activity involving many risks of injury. I understand that the dangers and risks of playing or practicing to play/participate in any sport(s) include, but are not limited to death, serious neck and spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints ligaments, tendons and other aspects of the body, general health and well-being. In understand that the dangers of playing or practicing to play/participate in sport(s) may result not only in serious injury, but in serious impairment/of my future abilities to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life.

Because of the dangers of participating in sport(s), I recognize the importance of following coaches' instructions regarding playing techniques, training and other team rules, etc., and agree to obey such instructions.

In consideration of Dyer County School System permitting me to try out for sport(s) and to engage in all activities related to the tearn(s), including, but not limited to, trying out, practicing, or playing/participating in the sport(s), I hereby assume all the risks associated with participation and agree to hold the Superintendent, Board of Education, and the Dyer County School System collectively and individually, its employees, agents, representatives, medical personnel, coaches, volunteers, including managers and trainers, harmless from any and all liability, actions, causes of actions, debts, claims or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to the Dyer County School System athletic team(s). The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees and for all members of my family.

DATE _____ STUDENT SIGNATURE _____

PARENT/GUARDIAN

I, _____ , am the parent/legal guardian of _____ (student), I have read the above warning and understand its terms. I understand that all sports can involve many risks of injury, including but not limited to, those risks outlined above.

In consideration of Dyer County School System permitting my child to try out for sport(s) and to engage in all activities related to the team(s), including, but mot limited to, trying out, practicing, playing/participating in that sport(s). I hereby agree to hold the Superintendent, Board of Education and Dyer County School System, collectively and individually, its employees, agents, representatives, medical personnel, coaches and volunteers, including trainers and managers, harmless from any and all liability, actions causes of actions, by or in connection with participation of my child/ward in any activities related to the Dyer county School System athletic team(s). The terms hereof shall serve as a release and assumption of risk for my heirs, estate, executor, administrator, assignees and for all members of my family.

DATE _____ PARENT/LEGAL GUARDIAN SIGNATURE _____

PARENTS' TRAVEL PERMIT

I hereby give my consent for _____ to travel to and from athletic events scheduled by the Dyer County School System Athletic Department. I understand the department policy will be to provide transportation by school bus, but in the event a buss is not available, private transportation may need to be used. These vehicles will be driven by adults (parents of athlete, coaches or teachers) or students and they cannot be held responsible for any accident or injury that might occur.

DATE _____ PARENT/LEGAL GUARDIAN SIGNATURE _____

NOTARY ACKNOWLEDGMENT
STATE OF TENNESSEE

COUNTY OF _____

Before me this day _____personally appeared who, being duly sworn, deposes and sates that he/she has read completely this document and has executed same as his/her own free act and agrees to be bound by its terms.

WITNESS my hand and seal this _____ day of _____

_____ Notary Public My commission expire _____

INSURANCE WAIVER

We, the parents or guardians of _____ do hereby acknowledge that an accident insurance policy is not in force for our son/daughter that will pay the medical or surgical expense that results from any injury, major or minor, that the above-named student may receive as a result of practicing or performing in athletics in the Dyer County School System.

Since we, the parents or guardians of the above-named student DO NOT HAVE AN INSURANCE POLICY which will provide adequate financial coverage for any type injury or injuries or whatever might result there from, we the parents or guardians agree to release the Superintendent, Board of Education, and the Dyer County School System, collectively and individually, its employees, agents, representatives, medical personnel, coaches and volunteers, including managers and trainers and trainers, from any obligation as pertains to financial responsibility to these matters for the _____ school year or any period of time thereafter.

DATE _____ PARENT/GUARDIAN SIGNATURE_____

We, the parents or guardians of _____ have insurance
(Student's name)

with _____ policy number _____
(name of insurance company)

That will pay the medical or surgical expenses that result from any injury, major or minor, that the above named student may receive as a result of practicing or performing in athletics in the Dyer County School System. This insurance will also over the above named student while traveling to or from practice sessions or scheduled performances.

Since we, the parents or guardians of the above named student, have an insurance policy which will provide adequate financial coverage for any type injury or injuries or whatever might result therefrom, we, the parents or guardians agree to release the Superintendent, Board of Education, and the Dyer County School System, collectively and individually, its employees, agents, representatives, medical personnel, coaches and volunteers, including managers and trainers, from any obligation as pertains to financial responsibility in these matters for the _____school year or any period of time thereafter.

DATE _____ PARENT/GUARDIAN SIGNATURE _____

NOTARY ACKNOWLEDGMENT

STATE OF TENNESSEE

COUNTY OF _____

Before me this day _____personally appeared who, being duly sworn, deposes and sates that he/she has read completely this document and has executed same as his/her own free act and agrees to be bound by its terms.

WITNESS my hand and seal this _____ day of _____

_____Notary Public My commission expire_____

Athlete/Parent/Guardian Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form

What is sudden cardiac arrest?
Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens, blood stops flowing to the brain and other vital organs. SCA doesn't just happen to adults; it takes the lives of students, too. However, the causes of sudden cardiac arrest in students and adults can be different. A youth athlete's SCA will likely result from an inherited condition, while an adult's SCA may be caused by either inherited or lifestyle issues. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?
SCA is the #1 cause of death for adults in this country. There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year. It is the #1 cause of death for student athletes.

Are there warning signs?
Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- fainting or seizures during exercise;
- unexplained shortness of breath;
- dizziness;
- extreme fatigue;
- chest pains; or
- racing heart.

These symptoms can be unclear in athletes, since people often confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?
There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who experience SCA die from it.

Public Chapter 325 – the Sudden Cardiac Arrest Prevention Act
The act is intended to keep youth athletes safe while practicing or playing. The requirements of the act are:

- All youth athletes and their parents or guardians must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.

Adapted from PA Department of Health: Sudden Cardiac Arrest Symptoms and Warning Signs Information Sheet and Acknowledgement of Receipt and Review Form. 7/2013

- The immediate removal of any youth athlete who passes out or faints while participating in an athletic activity, or who exhibits any of the following symptoms:
  (i) Unexplained shortness of breath;
  (ii) Chest pains;
  (iii) Dizziness
  (iv) Racing heart rate; or
  (v) Extreme fatigue; and

- Establish as policy that a youth athlete who has been removed from play shall not return to the practice or competition during which the youth athlete experienced symptoms consistent with sudden cardiac arrest

- Before returning to practice or play in an athletic activity, the athlete must be evaluated by a Tennessee licensed medical doctor or an osteopathic physician. Clearance to full or graduated return to practice or play must be in writing.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete

Print Student-Athlete's Name Date

Signature of Parent/Guardian

Print Parent/Guardian's Name Date

TN Department of Education

TN Department of Health

Sudden Cardiac Arrest
Symptoms and Warning Signs

What is Sudden Cardiac Arrest (SCA)?

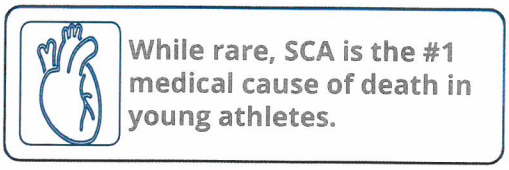
SCA is a life-threatening emergency that occurs when the heart suddenly and unexpectedly stops beating. This causes blood and oxygen to stop flowing to the rest of the body. The individual will not have a pulse. It can happen without warning and can lead to death within minutes if the person does not receive immediate help. Only **1 in 10** survives SCA. If Cardiopulmonary Resuscitation (CPR) is given and an Automatic External Defibrillator (AED) is administered early, **5 in 10** could survive.

SCA is NOT a heart attack, which is caused by reduced or blocked blood flow to the heart. However, a heart attack can increase the risk for SCA.

Watch for Warning Signs

SCA usually happens without warning. SCA can happen in young people who don't know they have a heart problem, and it may be the first sign of a heart problem. When there are warning signs, the person may experience:

If any of these warning signs are present, it's important to talk with a health care provider. There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops due to SCA, blood stops flowing to the brain and other body organs. Death or permanent brain damage can occur in minutes.



Electrocardiogram (EKG) Testing

EKG is a noninvasive, quick, and painless test that looks at the heart's electrical activity. Small electrodes attached to the skin of the arms, legs, and chest capture the heartbeat as it moves through the heart. An EKG can detect some heart problems that may lead to an increased risk of SCA. Routine EKG testing is not currently recommended by national medical organizations, such as the American Academy of Pediatrics and the American College of Cardiology, unless the pre-participation physical exam reveals an indication for this test. The student or parent may request, from the student's health care provider, an EKG be administered in addition to the student's pre-participation physical exam, at a cost to be incurred by the student or the student's parent.

Limitations of EKG Testing

- An EKG may be expensive and cannot detect all conditions that predispose an individual to SCA.

- False positives (abnormalities identified during EKG testing that turn out to have no medical significance) may lead to unnecessary stress, additional testing, and unnecessary restriction from athletic participation.
- Accurate EKG interpretation requires adequate training.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete	Print Student-Athlete's Name	Date

Signature of Parent/Guardian	Print Parent/Guardian's Name	Date

Department of Health Authorization No. 355864.
This Electronic publication was promulgated at zero cost.
July 2022

This publication was supported by the grant number 1 NU17CE010047-01-00 funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Student-athlete & Parent/Legal Guardian Concussion Statement

Must be **signed and returned** to school or community youth athletic activity prior to participation in practice or play.

Student-Athlete Name: _____

Parent/Legal Guardian Name(s): _____

After reading the information sheet, I am aware of the following information:

Student-Athlete initials		Parent/Legal Guardian initials
	A concussion is a brain injury, which should be reported to my parents, my coach(es), or a medical professional if one is available.	
	A concussion cannot be "seen." Some symptoms might be present right away. Other symptoms can show up hours or days after an injury.	
	I will tell my parents, my coach, and/or a medical professional about my injuries and illnesses.	N/A
	I will not return to play in a game or practice if a hit to my head or body causes any concussion-related symptoms.	N/A
	I will/my child will need written permission from a *health care provider** to return to play or practice after a concussion.	
	Most concussions take days or weeks to get better. A more serious concussion can last for months or longer.	
	After a bump, blow, or jolt to the head or body, an athlete should receive immediate medical attention if there are any danger signs such as loss of consciousness, repeated vomiting, or a headache that gets worse.	
	After a concussion, the brain needs time to heal. I understand that I am/my child is much more likely to have another concussion or more serious brain injury if return to play or practice occurs before the concussion symptoms go away.	
	Sometimes repeat concussion can cause serious and long-lasting problems, and even death.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

* *Health care provider* means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training

_____ _____

Signature of Student-Athlete Date

_____ _____

Signature of Parent/Legal guardian Date

Acknowledgement of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have received Sports Plus/LIFT Therapy's Notice of Privacy Practices.

Student-Athlete's Printed Name: _____

Student-Athlete's Signature: _____

Date: _____

For participants under 18 years of age:

I am the parent or guardian of _____and hereby acknowledge that I have received Sports Plus/LIFT Therapy's Notice of Privacy Practices.

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____

Date: _____

Release and Waiver

This release authorizes Sports Plus/LIFT Therapy to provide any emergency medical care, standard preventative care, and evaluation and treatment of injuries that may become reasonably necessary in the course of school athletic activities or school travel.

I, _____ (student-athlete), recognize that, as a result of my participation of sports activities, medical treatment on an emergency basis and standard treatment to prevent and treat injuries may be necessary. I authorize and consent to Sports Plus/LIFT Therapy to provide normal preventative care, such as, but not limited to, taping of joints, stretching of muscles, and applying topical medications. I authorize and consent to Sports Plus/LIFT Therapy to evaluate injuries and provide necessary treatments, such as, but not limited to, exercises, modalities, and hot or cold therapies. In the event of an emergency, I authorize Sports Plus/LIFT Therapy to secure any treatment deemed reasonable and necessary, and agree that I will be responsible for payment of any and all medical services rendered. I understand that Sports Plus/LIFT Therapy will not be responsible for any medical costs associated with any injury sustained or aggravated while participating in sports activities. I hereby agree to indemnify and hold harmless Sports Plus/LIFT Therapy from any loss, liability, damage or costs that I may incur due to or arising from my participation in sports activities.

Student-Athlete's Printed Name: _____

Student-Athlete's Signature: _____

Date: _____

For participants under 18 years of age:

I am the parent or guardian of _____and hereby authorize Sports Plus/LIFT Therapy to provide any emergency medical care, standard preventative care, and evaluation and treatment of injuries that may become reasonably necessary in the course of the student-athlete's school athletic activities or school travel. I recognize that _____ (school) personnel may be unable to contact me for my consent for emergency medical care. In the event of an emergency, I authorize Sports Plus/LIFT Therapy to secure any treatment deemed reasonable and necessary, and agree that I will be responsible for payment of any and all medical services rendered. I have read this release and intentionally and voluntarily accept its terms.

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____

Date: _____

Student-Athlete Authorization
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel from Jackson-Madison County General Hospital District d/b/a Sports Plus/LIFT Therapy ("Sports Plus/LIFT Therapy") to release and disclose all information regarding my protected health information and related information regarding any injury or illness occurring during training for and participation in athletics at _____ (school). This protected health information that may be disclosed includes my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, payment information, prognosis, and related personally identifiable health information. This protected health information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and governmental or school officials. The disclosure and release of the foregoing information is at my/our request.

I, _____ (student-athlete), understand that my giving authorization/consent for the disclosure of health information is a condition for participation as a student athlete at _____ (school) for the purpose of interscholastic sports. I understand that protected health information is protected by the federal regulations under the Health Insurance Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without authorization under HIPAA or consent under the Buckley Amendment, except in certain circumstances set forth in those laws. I understand that once information is disclosed per this Authorization, the information is subject to redisclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I understand that this Authorization is voluntary, that I may refuse to sign this Authorization, and that I may revoke this Authorization at any time by notifying Sports Plus/LIFT Therapy in writing, but if I do, such revocation will not have any effect on the actions that Sports Plus/LIFT Therapy took in reliance on this Authorization prior to receiving the revocation. This Authorization expires one year from the date it is signed.

Student-Athlete's Printed Name: _____

Student-Athlete's Signature: _____

Date: _____

For participants under 18 years of age:

I am the parent or guardian of _____and understand that my giving authorization/consent for the disclosure of the student-athlete's protected health information is a condition for participation in interscholastic sports. I have read this release and intentionally and voluntarily accept its terms.

Parent/Guardian's Printed Name: _____

Parent/Guardian's Signature: _____

Date: _____

CONSENT TO PHOTOGRAPH

I, _____, hereby grant and assign to Jackson-Madison County General Hospital District and/or West Tennessee Healthcare a non-exclusive, royalty-free license to use any and all photographs, videotapes, digital images, and audio recordings taken of me and/or my minor child by or for representatives of the system. I understand and agree that this material may be used in one or all of the following: radio or television broadcasts, newspaper or magazine articles, print materials, advertisements or on social media posts.

This consent will expire in five (5) years, unless I provide an alternate expiration date or event.

Signature: _____ Date:_____

Minor Child: _____ Relationship: _____

Address: _____

Phone Number: _____

Witness: _____

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (MARKETING/PUBLIC RELATIONS)

NAME:	Date of Birth:	SS No. (optional)
ADDRESS: TELEPHONE:	RELEASE PROTECTED HEALTH INFORMATION TO: JACKSON-MADISON COUNTY GENERAL HOSPITAL DISTRICT	

INFORMATION BEING RELEASED BY:

Purpose of Disclosure: ☐ At the Request of the Individual Identified Above
☐ Media, Public Relations, Marketing, Advertising, Posting, or Radio or Television Broadcasting
☐ Other, Please Explain:

Description of Information to be Used or Disclosed: _____Photographs/Video of me and/or my child
____Other (specify):

I understand that:

1. I may revoke this authorization in writing at any time, but if I do so, it will not have any effect on any actions taken by the facility releasing the information (hereafter referred to as "the facility") prior to the facility's receiving the revocation. Further details regarding the manner in which this authorization may be revoked may be found in the facility's Notice of Privacy Practices.
2. This authorization allows the facility to release the above requested documents. The released information may no longer be protected by federal privacy regulations and may be redisclosed.
3. The facility is hereby released from any liability and the undersigned will hold the facility harmless for complying with this authorization.
4. The facility will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except for research related purposes and as otherwise permitted under applicable law.
5. The authorization will expire in five (5) years unless I provide an alternate expiration date or event.
6. If the facility will use or disclose my protected health information for marketing purposes, the facility will not receive remuneration or compensation for such use or disclosure for marketing purposes unless the WTH Privacy Coordinator completes and signs the following statement:

I, _____ (signature of WTH Privacy Coordinator) hereby certify that the facility will receive remuneration or compensation for the use or disclosure of this patient's protected health information from _____ (fill in source of remuneration or compensation).

I have read and understood this authorization. I hereby authorize the use and disclosure of the above-requested protected health information.

_____ **Signature**

_____ **Signature of Authorized Representative**

_____ **Date**

_____ **Description of Representative's Authority to Act for Individual**

West Tennessee
HEALTHCARE

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Who We Are

This Notice describes the privacy practices of West Tennessee Healthcare and its hospitals and affiliates ("WTH"), including members of its workforce (employees and volunteers), the physician members of the medical staff, and allied health professionals who practice at WTH. WTH and the individual health care providers together are sometimes called "us" or "we" in this Notice. While we engage in many joint activities and provide services in a clinically integrated care setting, we each are separate legal entities (physician members of the staff and some allied health professionals are not employees, joint venturers, or agents of WTH).

II. Our Privacy Obligations

Each of us is required by law to maintain the privacy of your health information ("**Protected Health Information**" or "**PHI**") and to provide you with this Notice of our legal duties and privacy practices with respect to your Protected Health Information. When we use or disclose your Protected Health Information, we abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

III. Permissible Uses and Disclosures Without Your Written Authorization

In certain situations, which we will describe in Section IV below, we must obtain your written authorization on our authorization form ("**Your Authorization**") in order to use and/or disclose your PHI. However, we do not need any type of authorization from you for the following uses and disclosures:

A. Uses and Disclosures For Treatment, Payment and Health Care Operations. We may use and disclose PHI in order to treat you, obtain payment for services provided to you, and conduct our "health care operations" as detailed below:

- Treatment. We use and disclose your PHI to provide treatment and other services to you--for example, to diagnose and treat your injury or illness. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you after you leave WTH to inquire about your medical progress. We may also disclose PHI to other providers involved in your treatment.

- Payment. We may use and disclose your PHI to obtain payment for services that we provide to you--for example, disclosures to claim and obtain payment from your health insurer, HMO, or other

company that arranges or pays the cost of some or all of your health care ("**Your Payor**") to verify that Your Payor will pay for health care.

- Health Care Operations. We may use and disclose your PHI for our health care operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of the care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of physicians, nurses, and other health care workers. In addition, WTH may ask that you fill out and return a patient satisfaction survey and may contact you to remind you to fill out the survey as well as ask your opinion on your stay at WTH.

We may also disclose PHI to your other health care providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of health care professionals, or for health care fraud and abuse detection, or compliance. In addition, we may share PHI with our business associates who perform treatment, payment, and healthcare operations services on our behalf.

We may send your PHI to one or more health information exchanges (HIE), secure electronic systems through which your health care providers participating in the HIE may view certain records of your care for purposes of treatment, payment, and health care operations. Please contact our Privacy Coordinator at 731-541-8486 if you would like to learn more about the HIE and/or your option to restrict sharing of your information through HIE.

We may further share PHI with those health care providers and their authorized representatives that are members of organized health care arrangements in which we participate. Purposes of data sharing include utilization review and quality assessment and improvement activities.

B. Use or Disclosure for Directory of Individuals. We may include your name, location in WTH facility, general health condition, and religious affiliation in a patient directory without obtaining Your Authorization *unless* you object to inclusion in the directory. Information in the directory may be disclosed to anyone who asks for you by name or members of the clergy, provided, however, that religious affiliation will only be disclosed to members of the clergy.

C. Disclosure to Relatives, Close Friends and Other Caregivers. We may use or disclose your PHI to a family member, other relative, a close personal friend, or any other person identified by you when you are present for, or otherwise available prior to, the disclosure, if we (1) obtain your agreement; (2) provide you with the opportunity to object to the disclosure and you do not object; or (3) reasonably infer that you do not object to the disclosure.

If you are not present, or the opportunity to agree or object to a use or disclosure cannot be provided because of your incapacity or an emergency circumstance, we may exercise our professional judgment to determine whether a disclosure is in your best interest. If we disclose information to a family member, other relative, or a close personal friend, we would disclose only information that we believe is directly relevant to the person's involvement with your health care or payment related to your health care. We may also disclose your PHI in order to notify (or assist in notifying) a family member, other relative, or close personal friend of your location, general condition, or death.

D. Public Health Activities. As required or authorized by law, we may disclose your PHI for the following public health activities: (1) to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability; (2) to report child abuse and neglect to public health authorities or other government authorities authorized by law to receive such reports; (3) to report information about products and services under the jurisdiction of the U.S. Food and Drug Administration; (4) to alert a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or

spreading a disease or condition; and (5) to report information to your employer as required under laws addressing work-related illnesses and injuries or workplace medical surveillance.

E. Victims of Abuse, Neglect or Domestic Violence. If we reasonably believe you are a victim of abuse, neglect, or domestic violence, we may disclose your PHI to a governmental authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence.

F. Health Oversight Activities. We may disclose your PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance with the rules of government health programs such as Medicare or Medicaid.

G. Judicial and Administrative Proceedings. We may disclose your PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

H. Law Enforcement Officials. We may disclose your PHI to the police or other law enforcement officials as required or permitted by law or in compliance with a court order, a grand jury, or administrative subpoena.

I. Decedents. We may disclose your PHI to a coroner, medical examiner, or funeral director as authorized by law.

J. Organ and Tissue Procurement. To the extent required by law, we may disclose your PHI to organizations that facilitate organ, eye, or tissue procurement, banking, or transplantation.

K. Research. We may use or disclose your PHI to researchers when their research has been approved by an Institutional Review Board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI, and under other circumstances in accordance with regulations governing medical research. While most clinical research studies require specific patient consent, there are some instances when a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of certain patients with the same medical condition who received one medication to those who received another medication.

L. Health or Safety. We may use or disclose your PHI to prevent or lessen a serious and imminent threat to a person's or the public's health or safety.

M. Specialized Government Functions. We may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State, under certain circumstances.

N. Workers' Compensation. We may disclose your PHI as authorized by and to the extent necessary to comply with Tennessee law relating to workers' compensation or other similar programs.

O. As required by law. We may use and disclose your PHI when required to do so by any other law not already referred to in the preceding categories.

IV. Uses and Disclosures Requiring Your Written Authorization

A. Use or Disclosure with Your Authorization. For any purpose other than the ones described above in Section III, we only may use or disclose your PHI when you grant us Your Authorization. For

instance, you will need to execute an authorization form before we can send your PHI to your life insurance company. We will never sell PHI without Your Authorization.

B. Marketing. We must also obtain your written authorization ("**Your Marketing Authorization**") prior to using your PHI to send you any marketing materials. (We can, however, provide you with marketing materials in a face-to-face encounter without obtaining Your Marketing Authorization. We are also permitted to give you a promotional gift of nominal value, if we so choose, without obtaining Your Marketing Authorization.) In addition, we may tell you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers, or care settings without Your Marketing Authorization.

C. Uses and Disclosures of Your Highly Confidential Information. In addition, federal and state law requires special privacy protections for certain highly confidential information about you ("**Highly Confidential Information**"), including information about your PHI that: (1) is maintained in psychotherapy notes; (2) is about mental health and developmental disabilities services; (3) is about alcohol and drug abuse prevention, treatment, and referral; (4) is about HIV/AIDS testing, diagnosis, or treatment; (5) is about communicable disease(s); or (6) is about genetic testing. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain Your Authorization.

V. Your Rights Regarding Your Protected Health Information

A. For Further Information; Complaints. If you want further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Compliance Office. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Compliance Office will provide you with the correct address for the Director. We will not retaliate against you if you file a complaint with us or the Director.

B. Right to Request Additional Restrictions. You may request restrictions on our use and disclosure of your PHI (1) for treatment, payment, and health care operations, (2) to individuals (such as a family member, other relative, close personal friend, or any other person identified by you) involved with your care or with payment related to your care, or (3) to notify or assist in the notification of such individuals regarding your location and general condition. While we will consider all requests for additional restrictions carefully, we are not required to agree to a requested restriction unless you are restricting disclosure of PHI to a health plan and have paid out-of-pocket in full for the services. If you want to request additional restrictions, please obtain a request form from appropriate registration or admission personnel and submit the completed form to the Compliance Office.

C. Right to Receive Confidential Communications. You may request, and we will accommodate, any reasonable written request for you to receive your PHI by alternative means of communication or at alternative locations. For instance, we will send correspondence to an alternative mailing address.

D. Right to Opt Out of Fundraising Contacts. You may opt out of any fundraising contacts at any time.

E. Right to Revoke Your Authorization. You may revoke Your Authorization or Your Marketing Authorization, except to the extent we have already taken action based on the original authorization, by delivering a written revocation statement to the Compliance Office identified below.

F. Right to Inspect and Copy Your Health Information. You may request access to your medical record file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny your access to a portion of your records. If you want access to your records, please obtain a record request form from the appropriate medical records personnel and submit the completed form to the Medical Records/Health Information Management Department. Reasonable and cost-based copying fees will be imposed according to department polices and fee schedules.

G. Right to Amend Your Records. You have the right to request that we amend Protected Health Information maintained in your medical record file or billing records. If you want to amend your records, please obtain an amendment request form from appropriate medical records personnel and submit the completed form to the Medical Records/Health Information Management Department. We will comply with your request unless we believe that the existing information that would be amended is accurate and complete or other special circumstances apply.

H. Right to Receive An Accounting of Disclosures. Upon request, you may get an accounting of certain disclosures of your PHI made by us during any period of time prior to the date of your request provided the period does not exceed six years and does not apply to disclosures that occurred prior to April 14, 2003. The first accounting in any 12-month period is free. For each additional request by an individual in any 12-month period, WTH may charge a reasonable, cost-based fee, including reasonable retrieval and report preparation costs, as well as any mailing costs.

I. Right to Be Notified of Breach. You have the right to be notified after a breach of unsecured PHI.

J. Right to Receive Paper Copy of this Notice. Upon request, you may get a paper copy of this Notice, even if you have agreed to receive such notice electronically.

VI. Effective Date and Duration of This Notice

A. Effective Date. This Notice is effective on April 14, 2003.

B. Right to Change Terms of this Notice. We may change the terms of this Notice at any time. If we change this Notice, we may make the new notice terms effective for all Protected Health Information that we maintain, including any information created or received prior to issuing the new notice. If we change this Notice, we will post the new notice in waiting areas around **West Tennessee Healthcare** and on our Internet site at *www.wth.org*. You also may obtain any new notice by contacting the Compliance Office.

VII. Compliance Office

You may contact the Privacy Coordinator at:

Compliance Office
West Tennessee Healthcare
620 Skyline Drive
Jackson, Tennessee 38301
Telephone Number: (877) 746-3676 or (731) 541-8486

West Tennessee Healthcare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

CONCUSSION

INFORMATION AND SIGNATURE FORM
FOR STUDENT-ATHLETES & PARENTS/LEGAL GUARDIANS

(Adapted from CDC Heads Up Concussion in Youth Sports)

Read and keep this page.
Sign and return the signature page.

A concussion is a type of traumatic brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head or body that causes the head and brain to move rapidly back and forth. Even a "ding," "getting our bell rung," or what seems to be a mild bump or blow to the head can be serious.

Did You Know?

- Most concussions occur *without* loss of consciousness.
- Athletes who have, at any point in their lives, had a concussion have an increased risk for another concussion.
- Young children and teens are more likely to get a concussion and take longer to recover than adults.

WHAT ARE THE SIGNS AND SYMPTOMS OF 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 an athlete reports **one or more** symptoms of concussion listed below after a bump, blow, or jolt to the head or body, s/he should be kept out of play the day of the injury and until a health care provider says s/he is symptom-free and it's OK to return to play.

SIGNS OBSERVED BY COACHING STAFF	SYMPTOMS REPORTED BY ATHLETES
Appears dazed or stunned	Headache or "pressure" in head
Is confused about assignment or position	Nausea or vomiting
Forgets an instruction	Balance problems or dizziness
Is unsure of game, score, or opponent	Double or blurry vision
Moves clumsily	Sensitivity to light
Answers questions slowly	Sensitivity to noise
Loses consciousness (even briefly)	Feeling sluggish, hazy, foggy, or groggy
Shows mood, behavior, or personality changes	Concentration or memory problems
Can't recall events *prior* to hit of fall	Confusion
Can't recall events *after* hit of fall	Just not "feeling right" or "feeling down"

**Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training*

CONCUSSION DANGER SIGNS

In rare cases, a dangerous blood clot may form on the brain in a person with a concussion and crowd the brain against the skull. An athlete should receive immediate medical attention if after a bump, blow, or jolt to the head or body if s/he exhibits any of the following danger signs:

- One pupil larger than the other
- Is drowsy or cannot be awakened
- A headache that not only does not diminish, but gets worse
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Cannot recognize people or places
- Becomes increasingly confused, restless, or agitated
- Has unusual behavior
- Loses consciousness (*even a brief loss of consciousness should be taken seriously*)

WHY SHOULD AN ATHLETE REPORT THEIR SYMPTOMS?

If an athlete has a concussion, his/her brain needs time to heal. While an athlete's brain is still healing, s/he is much more likely to have another concussion. Repeat concussions can increase the time it takes to recover. In rare cases, repeat concussions in young athletes can result in brain swelling or permanent damage to their brain. *They can even be fatal.*

Remember:

Concussions affect people differently. While most athletes with a concussion recover quickly and fully, some will have symptoms that last for days, or even weeks. A more serious concussion can last for months or longer.

WHAT SHOULD YOU DO IF YOU THINK YOUR ATHLETE HAS A CONCUSSION?

If you suspect that an athlete has a concussion, remove the athlete from play and seek medical attention. Do not try to judge the severity of the injury yourself. Keep the athlete out of play the day of the injury and until a health care provider says s/he is symptom-free and it's OK to return to play.

Rest is key to helping an athlete recover from a concussion. 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. After a concussion, returning to sports and school is a gradual process that should be carefully managed and monitored by a health care professional.

* Health care provider means a Tennessee licensed medical doctor, osteopathic physician or a clinical neuropsychologist with concussion training