Cardinal Newman HIGH SCHOOL

AUTHORIZATION FOR SPORTS MEDICINE SERVICES AND CONSENT FOR TREATMENT

I, the undersigned, am the parent/legal guardian of, _____, a minor and student athlete at
(*Student-athlete name- please print*)

_____ who plans on participating in _____.
(*Name of school*) (*Sport*)

I understand that the Certified Athletic Trainer (ATC) is contracted by the school to provide sports medicine services for the school's student-athletes. I hereby give consent for an ATC and/or other sports medicine clinical staff to provide sports medicine services for the above minor. Sports medicine services include, but are not limited to: administering first aid for athletic injuries, providing initial treatment and management of acute injuries, and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Athletic Trainer and/or other sports medicine clinical staff will perform only those procedures that are within their training, credential limitations and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. I understand that a written report for any athletic injury assessment for the athlete will be confidentially maintained in the files of the athletic training room, athletics office or school nurse's office.

I, hereby authorize the Athletic Trainer and/or other sports medicine staff who provide services to the above-named athlete to disclose information about the athlete's injury assessments and post-injury status. I understand such disclosures will be done, as needed, with the involved coaching staff, Athletic Director of the school, the school nurse, any treating healthcare provider and/or consulting concussion management specialist.

I understand that there is no charge for me for the above listed athletic training services. If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the provider of his/her choice.

Injured athletes that have been evaluated and/or treated by a physician must submit written clearance from that physician to the Athletics Office/ Athletic Trainer prior to the athlete being permitted to resume activity. In circumstances where an athlete has been removed from play because of a suspected head injury or concussion, the athlete will not be permitted to return to play until the athlete is evaluated by a licensed health care provider, receives medical clearance and written authorization from that provider. This Authorization shall remain in effect for one calendar year beginning with the date set forth below.

Parent/Guardian Name _____ Signature _____
Date _____
Relationship to student athlete _____Cell/Work phone _____
Home Address _____ Home phone _____

Student Athlete Name _____ Signature _____
Sex _____Grade _____ Date of Birth _____
Allergies _____
Current Medications (ie asthma inhalers, epi-pen, etc) _____
Physical Impairments _____
Other Pertinent Medical History (surgeries, diabetes, seizures, heart condition, etc.) _____
_____
_____
Physician Name _____ Physician Phone _____

Pre-Participation Head Injury/Concussion Reporting:
Has student ever experienced a traumatic head injury (a blow to the head)? Yes___ No___If yes, when?_____
Has student ever received medical attention for a head injury? Yes __ No __ If yes, when? _____
If yes, please describe the circumstances: _____
Duration of symptoms (headache, difficulty concentrating, fatigue) for most recent concussion: _____

_____ _____
Student Athlete Signature *Parent/Guardian Signature*