HICKORY GROVE CHRISTIAN SCHOOL

ATHLETIC MEDICAL FORMS

"To Know Christ and To Make Him Known Through Christian Education"

ALL FORMS INCLUDED IN THIS PACKET MUST BE COMPLETED, SIGNED, AND RETURNED TO THE ATHLETIC DEPARTMENT BEFORE THE STUDENT MAY TRY OUT FOR ANY ATHLETIC TEAM AT HGCS.

Forms included in this packet:

- HGCS Emergency Medical Treatment Authorization
- Student-Athlete & Parent/Legal Custodian Concussion Statement
- CHS Release for Student Athletes
- CHS Request for Treatment and Authorization

Hickory Grove Christian School
Athletic Department
Emergency Medical Treatment Authorization Form

Student's Name_____ _____Date of Birth_____
Social Security Number_____Sex_____Grade_____
Home Address_____
Home Phone_____Cell Phone_____Work Phone_____

Please list parent/guardian names in the order in which you would like to be called in an emergency.
Parent/Guardian's Name_____Relationship_____
Phone: Home_____Business_____ Other_____
Parent/Guardian's Name_____Relationship_____
Phone: Home_____Business_____ Other_____

In case of divorce/separation, does child live with: mother?_____ father?_____ both?_____

If for any reason, I/we cannot be reached, please contact the following person(s) whom I/we hereby authorize to seek emergency medical or surgical care for my/our child.
Name:_____ Phone: Day_____ Evening_____
Name:_____ Phone: Day_____ Evening_____

Child's Physician_____ Physician's Phone_____

Food/allergies/sensitivities_____
Medication allergies/sensitivities_____
Existing medical problems_____
Medications child is taking_____
Additional comments_____

Insurance Coverage: Company_____ Policy Number_____
Subscriber_____ Employer_____
Subscriber's relationship to child_____

In the event that HGCS is unable to reach any of the individuals named above promptly by phone, I/we authorize a HGCS representative to seek and secure any emergency medical or surgical care for my/our child. I/We agree to be personally responsible for the payment of such medical expenses incurred. I/We authorize any charges to be billed to my/our insurance company. I/We further authorize the facility at which surgical or medical care is rendered to release all necessary information to my/our insurance company for purposes of reimbursement.

Parent/Guardian's Signature_____Date_____

AUTHORIZATION FOR PARTICIPATION IN INTERSCHOLASTIC ATHLETICS

As parent(s) or legal guardian(s) of _____ I/We hereby authorize and consent to our child's participation in interscholastic sports. I/We understand that there are risks and hazards associated with travel to and from the sites of such sports. Furthermore, I/We understand that the sports in which my/our child will be participating are potentially dangerous, and that physical injuries may occur to my/our child requiring emergency medical care and treatment.
I/We hereby agree to release and hold harmless Hickory Grove Christian School, its officers, trustees, agents, and employees, and agree to indemnify each of them, from any and all claims, costs, suits, actions, judgments, and expenses, upon any damage, loss, death, or injury to my/our child or damage to my/our child's property, arising from my/our child's participation in, including travel to and from the sites of interscholastic sports.

Parent/Guardian's Signature_____Date_____

CONCUSSION

INFORMATION FOR *STUDENT-ATHLETES & PARENTS/LEGAL CUSTODIANS*

What is a concussion? A concussion is an injury to the brain caused by a direct or indirect blow to the head. It results in your brain not working as it should. It may or may not cause you to black out or pass out. It can happen to you from a fall, a hit to the head, or a hit to the body that causes your head and your brain to move quickly back and forth.

How do I know if I have a concussion? There are many signs and symptoms that you may have following a concussion. A concussion can affect your thinking, the way your body feels, your mood, or your sleep. Here is what to look for:

Thinking/Remembering	Physical	Emotional/Mood	Sleep
Difficulty thinking clearly	Headache	Irritability-things bother you more easily	Sleeping more than usual
Taking longer to figure things out	Fuzzy or blurry vision	Sadness	Sleeping less than usual
Difficulty concentrating	Feeling sick to your stomach/queasy	Being more moody	Trouble falling asleep
Difficulty remembering new information	Vomiting/throwing up	Feeling nervous or worried	Feeling tired
	Dizziness	Crying more	
	Balance problems		
	Sensitivity to noise or light		

Table is adapted from the Centers for Disease Control and Prevention (http://www.cdc.gov/concussion/)

What should I do if I think I have a concussion? If you are having any of the signs or symptoms listed above, you should tell your parents, coach, athletic trainer or school nurse so they can get you the help you need. If a parent notices these symptoms, they should inform the school nurse or athletic trainer.

When should I be particularly concerned? If you have a headache that gets worse over time, you are unable to control your body, you throw up repeatedly or feel more and more sick to your stomach, or your words are coming out funny/slurred, you should let an adult like your parent or coach or teacher know right away, so they can get you the help you need before things get any worse.

What are some of the problems that may affect me after a concussion? You may have trouble in some of your classes at school or even with activities at home. If you continue to play or return to play too early with a concussion, you may have long term trouble remembering things or paying attention, headaches may last a long time, or personality changes can occur Once you have a concussion, you are more likely to have another concussion.

How do I know when it's ok to return to physical activity and my sport after a concussion? After telling your coach, your parents, and any medical personnel around that you think you have a concussion, you will probably be seen by a doctor trained in helping people with concussions. Your school and your parents can help you decide who is best to treat you and help to make the decision on when you should return to activity/play or practice. Your school will have a policy in place for how to treat concussions. You should not return to play or practice on the same day as your suspected concussion.

You should not have any symptoms at rest or during/after activity when you return to play, as this is a sign your brain has not recovered from the injury.

This information is provided to you by the UNC Matthew Gfeller Sport-Related TBI Research Center, North Carolina Medical Society, North Carolina Athletic Trainers' Association, Brain Injury Association of North Carolina, North Carolina Neuropsychological Society, and North Carolina High School Athletic Association.

Student-Athlete & Parent/Legal Custodian Concussion Statement

**If there is anything on this sheet that you do not understand, please ask an adult to explain or read it to you.*

Student-Athlete Name:_____

This form must be completed for each student-athlete, even if there are multiple student-athletes in each household.

Parent/Legal Custodian Name(s):_____

□ We have read the *Student-Athlete & Parent/Legal Custodian Concussion Information Sheet.*
If true, please check box.

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

Student-Athlete Initials		Parent/Legal Custodian 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 can affect the ability to perform everyday activities such as the ability to think, balance, and classroom performance.	
	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
	If I think a teammate has a concussion, I should tell my coach(es), parents, or medical professional about the concussion.	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 medical professional trained in concussion management to return to play or practice after a concussion.	
	Based on the latest data, most concussions take days or weeks to get better. A concussion may not go away right away. I realize that resolution from this injury is a process and may require more than one medical evaluation.	
	I realize that ER/Urgent Care physicians will not provide clearance if seen right away after the injury.	
	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 concussion symptoms go away.	
	Sometimes, repeat concussions can cause serious and long-lasting problems.	
	I have read the concussion symptoms on the Concussion Information Sheet.	

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Parent/Legal Custodian Date

Patient Information: I give permission to release the health information of: **(One Patient Per Form)**

Patient Name: _____ Date of Birth: _____

Street Address: _____ Last 4 numbers of SSN:_____

City, State, Zip: _____ Telephone: ( ) _____

Email address: _____

Release Information From:

Carolinas Healthcare System

_____
(List applicable Facility(s) and/or Practice(s)

_____

_____
(Phone number) (Fax number)

Release Information To:

Hickory Grove Christian School _____
(Name of facility, person, company) (Relationship)

7200 E. WT Harris Blvd. Charlotte, NC 28215 _____
(Street Address or PO Box, City, State, Zip Code)

704-531-4198 _____
(Phone number) (Fax number)

PURPOSE OF RELEASE (check reason): ☐ Request of individual/personal ☐ Continued patient care ☐ Insurance
☐ Legal purpose including discussions & proceedings ☒ Other **Sports Medicine including oral & written communication**

Fill in dates of treatment for records to be released:

Treatment dates: From August 1st, 2017 **To** July 31st, 2018

Hospital Summary: May include history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies.

Office/Clinic Summary: May include most recent office visits, physical exam, consults, diagnostic test results.

Hospital (check all that may apply):
☐ Hospital Summary
☐ Discharge Summary ☐ Emergency Record
☐ History and Physical ☐ Cardiac Reports/EKG
☐ Consultation reports ☐ Other_____
☐ Operative Reports _____
☐ Laboratory reports _____
☐ Radiology/X-Ray Reports _____
☐ Pathology reports _____

☐ Entire record (Not including psychotherapy notes)

Office/Clinic (check all that may apply):
☐ Office/Clinic Summary
☐ Office Visits
☒ **Physical Exam**
☒ **Laboratory Reports**
☒ **Radiology Reports**
☒ **Other_Research Participation**

☐ Entire Record (Not including psychotherapy notes)

Behavioral Health/Sub. Abuse (check all that may apply):
☐ Hospital Summary
☐ Assessments
☐ Discharge Summary
☐ Physician Orders
☐ Progress notes
☐ Medications
☐ Lab reports
☐ Other _____

☐ Entire Record (Not including psychotherapy notes)

FORMAT:
☐ CD (charges may apply)
☐ Email Address noted above, where permitted
☐ Paper copy (charges may apply)
☐ Other_____

DELIVERY METHOD:
☐ Reg.US Mail ☐ Pick-up ☐ Fax, where permitted
☐ Overnight/Express Mail Service, where permitted
☐ Secure email
☐ Other: _____

PATIENT'S RIGHTS – I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **This is a full release including information related to behavioral/mental health, drug and alcohol abuse treatment (in compliance with 42 CFR Part 2), genetic information, HIV/AIDS, and other sexually transmitted diseases.**
- **Once my health information is released, the recipient may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections.**
- **Refusing to sign this form will not prevent my ability to get treatment, payment, enrollment in health plan, or eligibility for benefits.**
- **CHS will not share or use my health information without my permission other than by ways listed in CHS's Notice of Privacy Practices or as required by law. The Notice of Privacy Practices is available at carolinashealthcare.org.**
- **A fee may be charged for providing the protected health information.**
- **I have a right to receive a copy of this form upon request.**

This permission expires one year after the date of my signature unless another date or event is written here: _____

Signature: _____ **Print Name:** _____ **Date:**_____

Note: If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.
Note the relationship/authority if signature is not that of the patient (Written Proof May be Requested):
☐ **Healthcare Agent/POA** ☐ **Guardian** ☐ **Executor/Administrator/Attorney in Fact** ☐ **Spouse**
☐ **Parent** ☐ **Adult Child** ☐ **Affidavit Next of Kin** ☐ **Other:** _____

Note: If minor consented for their outpatient treatment for pregnancy, sexually transmitted disease or behavioral/mental health without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this authorization, regardless of who consented for treatment.

Signature of Minor:_____ **Print Name:** _____ **Date:** _____

Authorization given to patient / Date of release:_____via ☐Mail ☐Fax ☐Other_____☐**ID Verified** ☐**DL/Other ID**_____
CHS Employee Name & Title: _____**CHS Employee Signature:** _____**Date:**_____

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Carolinas HealthCare System
AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Information or Sticker
Name:
DOB:
Medical Record #:
Account #:

Carolinas HealthCare System

REQUEST FOR TREATMENT AND AUTHORIZATION FORM

REQUEST FOR TREATMENT. The Hospital maintains personnel and facilities to assist my physicians in providing me medical care, and I authorize the Hospital personnel to perform on me the care ordered by my physicians. I understand that I have the right to be informed by my physicians of the nature and purpose of any proposed operation or procedure and any available alternative methods of treatment, together with an explanation of the risks associated with each of them. This form is not a substitute for such explanations, which are the responsibility of my physicians to provide according to recognized standards of medical practice, and I acknowledge that the Hospital and its personnel are not responsible for providing me this information. I consent to receive services by telemedicine (using interactive audio, video, or data communications to carry out consultations, evaluations, screenings, diagnosis, treatment, monitoring, or other communications benefiting a patient) if appropriate for my condition, and I understand the risks, benefits and alternatives of doing so.

I authorize the Hospital and my physicians/athletic trainers to take pictures and/or video of me for treatment and health care operation purposes.

I have read the foregoing request and authorization in its entirety and agree to be bound by all terms and conditions herein. Witness my (our) hand(s) below.

_____ _____

Patient Name Printed Responsible Party/ies Parent/Guardian Signature

_____

Date

_____

Witness

I have been provided access to CHS's Notice of Privacy Practices

Signature _____ Date:_____ Time:_____
(Patient or Authorized Representative)

Relationship to Patient:_____

Reason Patient Unable/Unwilling to sign_____

CAROLINAS HEALTHCARE SYSTEM

Category: Patient Rights
Policy: Patient Rights
Number: PR 100.00
Date of Issue: 07/94 Reviewed / Revised: 01/12

PATIENT RIGHTS POLICY STATEMENT

The Carolinas HealthCare System will provide impartial access to available medical treatment. Patients will receive high quality care which demonstrates respect for their values and beliefs and which recognizes their personal dignity and need for privacy in treatment. Patients will have sufficient information to participate in decisions relating to their treatment. A mechanism will exist to identify issues of concern, to resolve grievances and to improve patient care and services of Carolinas HealthCare System.

Each patient will receive information regarding his/her rights and responsibilities at the earliest possible time in the course of their care.

Approved: _____
Joseph G. Piemont, President and COO