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
- Atrium Health Consent Form

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

Carolinas HealthCare System is

Atrium Health

Student Athlete Request For Treatment
Release Of Medical Information
Photo And Video Release

Name of Student Athlete: _____

Request For Treatment

My/child's school has engaged Atrium Health ("AH") to support and provide healthcare services for students, athletic staff, and others. I give permission for AH providers/athletic trainers/registered dietitians ("AH Sports Medicine Team") to provide me/my child with care deemed appropriate by the AH Sports Medicine Team. I understand that I have the right for an explanation to the nature and purpose of any proposed procedure and other options for treatment. I understand an explanation of the risks associated with each of them in accordance with the recognized standards of medical and healthcare practice will be provided. If my child is under 18, I confirm that my child can request and receive care on their own from the AH Sports Medicine Team and I consent to the AH Sports Medicine Team providing that care. I agree the AH Sports Medicine Team may refer me/my child to an outside provider and that I/my child may engage in a separate provider-patient relationship. I/my child consent to receive services by telemedicine (using interactive audio, video, or data communications to carry out healthcare benefiting a patient) if appropriate for my/child's condition, and I understand the risks, benefits and alternatives of doing so. This Request for Treatment is valid for two years from the date signed below.

Release Of Medical Information

I give permission for Atrium Health ("AH") to share my/my child's medical information related to or arising from the AH Sports Medicine Team (including clinical, lab and radiology reports) with other AH providers, independent providers, the school system, or other school sports program representatives (such as coaches and school-employed athletic trainers). I understand and agree that the AH Sports Medicine Team may use and share my/child's information to coordinate care outside of the school's athletic program. I understand that AH is providing the services under an agreement with the school system and I agree that it may share my/my child's information with the school system or store information on school system platforms. This Release of Medical Information will be valid for two years from the date signed below.

I have read and agree to the above Request for Treatment and Release of Medical Information.

_____	_____	_____
Printed Name of Student over 18 or Parent/Guardian	Student over 18 or Parent/Guardian Signature	Date

Photo/Video Consent And Release And Communication Authorization

I give Atrium Health ("AH") the unlimited right to use and/or reproduce photographs, video, likenesses or the voice of me/my child in any legal manner and for the internal or external promotional and information activities of AH, including on closed or public websites/intranet web pages/social media sites used by AH or the school. This permission includes allowing the AH Sports Medicine Team and AH to post pictures of me/my child at a sporting events, at school, or in the athletic training rooms. I also agree that the AH Sports Medicine Team may use unsecured methods to communicate with me/my child, such as through unencrypted email or social media platforms or engines. I understand the risks of using these communications and agree that AH may use them to communicate with me/my child, such as to make appointments to see the AH Sports Medicine Team or to follow up on care. I also agree, for myself and my child, to give up any present or future compensation rights to use of the above stated materials. This Photo/Video Consent and Release and Communication Authorization will be valid until AH does not need the information and images any longer.

I have read and agree to the above Photo/Video Consent and Release and Communication Authorization.

_____	_____	_____
Printed Name of Student over 18 or Parent/Guardian	Student over 18 or Parent/Guardian Signature	Date