Dear Parents/Guardians of University of St. Francis Athletes,

Parkview is excited to provide you with medical care for the upcoming year of USF athletics. We look forward to getting to know each student-athlete and providing them with the best possible care.

Parkview Sports Medicine (PSM) which includes the specialties of Orthopaedics NorthEast (ONE), Athletes with Purpose (AWP), Parkview Athletic Rehab (PAR) and Parkview Ortho Hospital will be providing comprehensive orthopedic coverage and care for the student-athletes. There is also a sports nutritionist/dietitian for consultation on any and all nutritional questions and concerns. A physical on any and all nutritional questions and concerns. A Physical Therapist will be on campus to work closely with the athlete and athletic trainer to return an athlete to play as soon as possible. The team physician will be on campus weekly as well as periodic visits from the team surgeon. Student-athletes will also have access to sports performance enhancement through AWP. All medical care will be coordinated through the Sports Medicine staff for best possible care of the student-athlete.

If your student-athlete has any injuries during their career at USF, they should inform an athletic trainer immediately. This allows the sports medicine staff to properly care for and treat the injured athlete. Our staff will work closely with the coaches and student-athletes in preventative strategies. If an injury occurs that requires evaluation by an orthopedic physician, we will make a priority appointment for your student-athlete at ONE. All physician visits, diagnostics, treatment and rehabilitation not able to be performed at USF will be billed to the student-athlete’s primary insurance first, followed by the university’s secondary insurance only if the injury occurred during official practices and games. In some circumstances, a bill for medical services may be forwarded to you from various providers for which you may have some financial responsibilities. **If you receive any bill, please forward it to the USF Sports Medicine Staff as soon as possible.** This allows us to give you directions on how it should be handled according to USF procedures. **Ultimately, payment for all medical bills is the responsibility of the student-athlete, so please make sure you communicate with us regarding any bills you receive.** If you have any questions regarding medical tests, visits, procedures, or your financial responsibilities, please feel free to contact us. **The school’s secondary athletic insurance company can also reimburse you for the cost of prescriptions due to an injury in USF athletics.**

The NAIA does not permit USF or any of its other institutions to pay medical expenses related to “illnesses”, “conditions”, or injuries which were not sustained as the direct result of an accident in USF intercollegiate sports program. All treatments will be performed in one of USF’s athletic training rooms or at a Parkview facility as needed.

**If your child uses a rescue inhaler, please see that they turn one in to their athletic trainer.** In the event that they need it, we will have it available.

There are 4 pieces of information that **MUST** be completed and received by the Sports Medicine Staff before the student-athlete is allowed to participate in USF athletics.

1. The **USF Physical** form can be downloaded from the Athletic Training page of the USF Athletics Website. Please be sure to fill out the entire form and sign it on the back. **A physician must complete a portion of the form.**
2. **All athletes must be covered under a primary insurance policy.** We need a copy of the card(s) for proof of insurance. If your student-athlete is not covered under a primary insurance, an accident policy can be purchased from the same company that provides our secondary insurance or you can purchase a medical policy on your own. The accident policy only covers injuries incurred during USF athletics and is not the same as a medical insurance policy. Feel free to contact us if you have any questions. Application forms can be picked up from any athletic trainer.

3. Please download and submit the Consent to treat and Medical Information Form. This gives us and other medical professionals permission to treat an injury to your student-athlete if they are unable to communicate with us. That form also allows Parkview Sports Medicine to use media featuring your student-athlete.

4. Lastly, you will also notice informational brochures on the webpage regarding Concussions and Sudden Cardiac Arrest as well as a short video about concussions. Please read these brochures and watch the video, then share them with your student-athlete for his/her signature on the acknowledgement form. The Concussion and Sudden Cardiac Arrest Acknowledgement form must be submitted according to Indiana State Law.

   All paperwork should be submitted by August 1, or your first practice, whichever comes first.

We hope your student-athlete has a healthy and successful season!

Go Cougars!

---

Julie Reinking, MPM, LAT, ATC  
Office: (260) 399-7700 x6208  
Cell: (260) 413-0428  
Email: jareinking@sf.edu

Zach Ruble, MEd, LAT, ATC  
Office: (260) 399-7700 x6208  
Cell: (260) 402-2633  
Email: zruble@sf.edu

Sarah Allison, LAT, ATC  
Office: (260) 399-7700 x6208  
Cell: (574) 551-8192  
Email: sallison@sf.edu

John Patton, MBH, LAT, ATC  
Office: (260) 399-7700 x6208  
Cell: (260) 415-8689
University of St. Francis
New Athlete Physical

Athlete Information

Name: ________________________  Birthdate: __________  Sport: ________________________

Male □  Female □  Year in School: ________________  SSN: ____________________________

Address: __________________________  City: ______________  State: ______  Zip: ______

Student-Athlete Cell: __________________________  E-Mail: ____________________________

Primary Insurance

Insurance Company: ________________________  Policy/ID #: __________________________

Group #: __________________________  Customer Service Phone: ______________________

Policy Holder: ________________________  Policy Holder Date of Birth: ________________

Parent Information

Father: ________________________  Phone: __________________________

Mother: ________________________  Phone: __________________________

In Case Of Emergency

Contact: ________________________  Relationship: ________________________________

Address: ________________________________  Phone: ________________________________
### GENERAL QUESTIONS

1. Has a doctor ever denied or restricted your participation in sports for any reason or told you to give up sports? ................................................................. Y / N
2. Do you have an ongoing medical condition (like diabetes, asthma, anemia, infections)? .............................................................................................................. Y / N
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? ................................................................. Y / N
   - List: ........................................................................................................
4. Do you have allergies to medicines, pollens, foods, or stinging insects? .............................................................................................................. Y / N
5. Have you ever spent the night in a hospital? ................................................................................................................................. Y / N
6. Have you ever had surgery? ................................................................................................................................. Y / N

### HEART HEALTH QUESTIONS ABOUT YOU

7. Have you ever passed out or nearly passed out DURING exercise? .............................................................................................................. Y / N
8. Have you ever passed out or nearly passed out AFTER exercise? .............................................................................................................. Y / N
9. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise? ............................................................................ Y / N
10. Does your heart race or skip beats (irregular beats) during exercise? ................................................................................................. Y / N
11. Has a doctor ever told you that you have? (circle):
   - High blood pressure
   - A heart murmur
   - High cholesterol
   - A heart infection
   - Rheumatic fever
   - Kawasaki’s Disease
12. Has a doctor ever ordered a test for your heart? (for example, ECG/EKG, echocardiogram, stress test) ................................................................. Y / N
13. Do you get lightheaded or feel more short of breath than expected during exercise? ................................................................................................. Y / N
14. Have you ever had an unexplained seizure? ................................................................................................................................. Y / N
15. Do you get more tired or short of breath more quickly than your friends during exercise? ................................................................................................. Y / N

### HEART HEALTH QUESTIONS ABOUT YOUR FAMILY

16. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including unexplained drowning, unexplained car accident, or sudden infant death syndrome)? ........................................................................................................................................... Y / N
17. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia? ........................................................................................................................................... Y / N
18. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator? .............................................................................................................. Y / N
19. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning? ........................................................................................................ Y / N

### BONE AND JOINT QUESTIONS

20. Have you ever had an injury, like a sprain, muscle or ligament tear or tendonitis that caused you to miss a practice or game? ................................. Y / N
21. Have you had any broken or fractured bones or dislocated joints? .............................................................................................................. Y / N
22. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches? ................................................................. Y / N
23. Have you ever had a stress fracture? ........................................................................................................................................... Y / N
24. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism) Y / N
25. Do you regularly use a brace, orthotics or other assistive device? .............................................................................................................. Y / N
26. Do you have a bone, muscle, or joint injury that bothers you? .............................................................................................................. Y / N
27. Do any of your joints become painful, swollen, feel warm, or look red? .............................................................................................................. Y / N
28. Do you have any history of juvenile arthritis or connective tissue disease? .............................................................................................................. Y / N

### MEDICAL QUESTIONS
29. Has a doctor ever told you that you have asthma or allergies? .......................................................... Y / N  
30. Do you cough, wheeze, experience chest tightness, or have difficulty breathing during or after exercise? .......................................................... Y / N  
31. Is there anyone in your family who has asthma? .................................................................................. Y / N  
32. Have you ever used an inhaler or taken asthma medicine? ................................................................. Y / N  
33. Do you develop a rash or hives when you exercise? ............................................................................. Y / N  
34. Were you born without or are you missing a kidney, an eye, a testicle (males), or any other organ? .................................................................................. Y / N  
35. Do you have groin pain or a painful bulge or hernia in the groin area? .................................................. Y / N  
36. Have you had infectious mononucleosis (mono) within the last month? .............................................. Y / N  
37. Do you have any rashes, pressure sores, or other skin problems? ..................................................... Y / N  
38. Have you had a herpes or MRSA skin infection? ................................................................................... Y / N  
39. Have you ever had a head injury or concussion? .................................................................................. Y / N  
40. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems? .................................................................................. Y / N  
41. Do you have a history of seizure disorder? ............................................................................................ Y / N  
42. Do you have headaches with exercise? .................................................................................................. Y / N  
43. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? .................................................................................. Y / N  
44. Have you ever been unable to move your arms or legs after being hit or falling? .................................. Y / N  
45. Have you ever become ill while exercising in the heat? ........................................................................ Y / N  
46. Do you get frequent muscle cramps when exercising? ......................................................................... Y / N  
47. Do you or someone in your family have sickle cell trait or disease? .................................................... Y / N  
48. Have you had any problems with your eyes or vision? ......................................................................... Y / N  
49. Have you had any eye injuries? ............................................................................................................... Y / N  
50. Do you wear glasses or contact lenses? ................................................................................................ Y / N  
51. Do you wear protective eyewear, such as goggles or a face shield? ..................................................... Y / N  
52. Do you worry about your weight? .......................................................................................................... Y / N  
53. Are you trying to or has anyone recommended that you gain or lose weight? .................................... Y / N  
54. Are you on a special diet or do you avoid certain types of foods? .......................................................... Y / N  
55. Have you ever had an eating disorder? .................................................................................................. Y / N  
56. Do you have any concerns that you would like to discuss with a doctor? ............................................ Y / N  

**FEMALES ONLY**

57. Have you ever had a menstrual period? ............................................................................................... Y / N  
58. How old were you when you had your first menstrual period? _____  
59. How many menstrual periods have you had in the last year? _____  

Notes:_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
Follow-Up Questions About More Sensitive Issues:

1. Do you feel stressed out or under a lot of pressure?
2. Do you ever feel so sad or hopeless that you stop doing some of your usual activities for more than a few days?
3. Do you feel safe?
4. Have you ever tried cigarette, cigar, or pipe smoking, even 1 or 2 puffs? Do you currently smoke?
5. During the past 30 days, did you use chewing tobacco, snuff, or dip?
6. During the past 30 days, have you had any alcohols, even just one?
7. Have you ever taken steroid pills or shots without a doctor's prescription?
8. Have you ever taken any medications or supplements to help you gain or lose weight or improve your performance?
9. Question “Risk Behaviors” like guns, seatbelts, unprotected sex, domestic violence, drugs, and others.

Notes About Follow-Up Questions:
# MEDICAL EXAM

**Height** ______  **Weight**_______  

**Pulse** _______  **BP** ______ / ______ (______/______)

**Vision:** R 20/____  L 20/____  Corrected: Y / N  **Contacts:** Y / N

<table>
<thead>
<tr>
<th>Exam</th>
<th>Normal</th>
<th>Abnormal Notes</th>
<th>Initials*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span &gt; height, hyperlaxity, myopia, MVP, aortic insufficiency)</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HEENT</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fundoscopic</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pupils</td>
<td>Equal / Unequal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Murmurs (standing, supine, +/- Valsalva)</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PMI location</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pulses (simultaneous femoral &amp; radial)</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin (No HSV, MRSA, Tinea corporis)</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shoulder/Arm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elbow/Forearm</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wrist/Hand/Fingers</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hip/Thigh</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leg/Ankle</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot/Toes</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Functional (Single Leg Hop or Squat, Box Drop)</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** ____________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

_____________________________________________________________________

________  Cleared for Participation  

________  Restricted Participation  

________  May Not Participate  

**Physician Signature:** _________________________________  

**Date:** ______
## WHAT IS A CONCUSSION?
A concussion is a brain injury that:
- Is caused by a blow to the head or body.
- Can occur during practice or competition in ANY sport.
- Can happen even if you do not lose consciousness.

### HOW CAN I PREVENT A CONCUSSION?
Basic steps you can take to protect yourself from concussion:
- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and stick to the head all cause concussions.
- Follow your athletic department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

## WHAT ARE THE SYMPTOMS OF A CONCUSSION?
You can’t see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:
- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy, or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms such as headache or tiredness to reappear or get worse.

## WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?
Don’t hide it. Tell your athletic trainer and coach. Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion.

Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play.

A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.

## IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON.
WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.
University of St. Francis
Student-Athlete Concussion Statement

☐ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and/or team physician.

☐ I have read and understand the NCAA Concussion Fact Sheet.

After reading the NCAA Concussion Fact Sheet, I am aware of the following information (Please initial each line):

_____ A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.

_____ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

_____ You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

_____ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.

_____ I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.

_____ Following a concussion, the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.

_____ In rare cases, repeat concussions can cause permanent brain damage, and even death.

______________________________
Signature of Student-Athlete

______________________________
Date

______________________________
Printed name of Student-Athlete
Sudden Cardiac Arrest Fact Sheet
A Fact Sheet for Student Athletes

Facts
Sudden Cardiac arrest can occur even in athletes who are in peak shape. Approximately 500 deaths are attributed to sudden cardiac arrest in athletes each year in the United States. Sudden cardiac arrest can affect all levels of athletes, in all sports, and in all age levels. The majority of cardiac arrests are due to congenital (inherited) heart defects. However, sudden cardiac arrest can also occur after a person experiences and illness which has caused an inflammation to the heart or after a direct blow to the chest. Once a cardiac arrest occurs, there is very little time to save the athlete, so identifying those at risk before the arrest occurs is a key factor in prevention.

Warning signs
There may not be any noticeable symptoms before a person experiences a loss of consciousness and a full cardiac arrest (no pulse, no breathing).

Warning signs can include a complaint of:
- Chest Discomfort
- Unusual Shortness of Breath
- Racing or Irregular Heartbeat
- Fainting or Passing Out

Emergency Signs-Call EMS (911)
If a person experiences any of the following signs, call EMS (911) immediately:
- If an athlete collapses suddenly during competition
- If a blow to the chest from a ball, puck or another player precedes an athlete’s complaints of any of the warning signs of sudden cardiac arrest.
- If an athlete does not look or feel right and you are just not sure.

Developed and Reviewed by the Indiana Department of Education’s Sudden Cardiac Arrest Advisory Board (1-7-15)
How can I help prevent a sudden cardiac arrest?

Daily physical activity, proper nutrition, and adequate sleep are all important aspects of lifelong health. Additionally, you can assist by:

- Knowing if you have a family history of sudden cardiac arrest (onset of heart disease in a family member before the age of 50 or a sudden, unexplained death at an early age)
- Telling your health care provider during your pre-season physical about any unusual symptoms of chest discomfort, shortness of breath, racing or irregular heartbeat, or feeling faint, especially if you feel these symptoms with physical activity.
- Taking only prescription drugs that are prescribed to you by your health care provider
- Being aware that the inappropriate use of prescription medications or energy drinks can increase your risk
- Being honest and reporting symptoms of chest discomfort, unusual shortness of breath, racing or irregular heartbeat, or feeling faint.

What should I do if I think I’m developing warning signs that may lead to sudden cardiac arrest?

1. Tell an adult—your parent or guardian, your coach or your athletic trainer
2. Get checked out by your healthcare provider
3. Take care of your heart
4. Remember that the most dangerous thing you can do is to do nothing.

By signing below, I acknowledge that I understand the risk of sudden cardiac arrest associated with athletics. I understand that it is my responsibility to inform my teammates, coaches, and/or athletic trainer if I have symptoms of cardiac arrest. I also understand that I will not return to activity without clearance signed by a healthcare professional.

_______________________________________                                                              _________________
Student-Athlete Printed Name                                                                   Date

_______________________________________              _______________________________________
Student-Athlete Signature                                                                Signature of Parent/Guardian if under 18
PARKVIEW
ORTHO HOSPITAL

Parkview Sports Medicine

Consent to Treat

I hereby authorize medical treatment for said athlete at (School Name) by the athletic trainers, physicians, and staff of Parkview Ortho Performance Center d/b/a Parkview Sports Medicine. A family member can be reached at ________________ in the event additional treatment or information is required. I understand that if the said athlete is seen by a physician or other provider at Parkview Sports Medicine and my insurance requires prior approval, I will be responsible for notifying the appropriate party in order to obtain approval.

Student Name_________________________ Student Signature_________________________

Mailing Address ______________________ City/State/Zip ______________________________

Date_________________________ Student Date of Birth ______________________________

Parent/Guardian Name__________________ Parent/Guardian Signature________________________

Acknowledgement of Receipt or Declination of Notice of Privacy Practices

I acknowledge that Parkview Ortho Performance Center d/b/a Parkview Sports Medicine (PSM) has offered me a copy of its Notice of Privacy Practices. The Notice describes how Parkview may use and disclose my protected health information, certain restrictions on the use and disclosure of my health information, and rights that I have regarding my health information. I understand that I should read it carefully. By signing this Acknowledgement, I acknowledge that I have received a copy of the Notice.

The Notice of Privacy Practices is also available at the front desk at all PSM offices and on the PSM web site at www.parkviewsportsmedicine.com. Parkview reserves the right to change the Notice at any time. I understand that I can obtain any revisions to the Notice by accessing the PSM web site, calling PSM and requesting a copy of the Notice be mailed to me or asking for one at the time of my next appointment.

Student Name_________________________ Student Signature_________________________

Parent/Guardian Name__________________ Parent/Guardian Signature________________________

Date_________________________ Student Date of Birth ______________________________

Interview/Photographic Release

I hereby authorize Parkview Ortho Performance Center d/b/a Parkview Sports Medicine and its employees to interview, photograph and videotape (Name of Athlete) while participating in athletic events, practices and other functions associated with athletics at the above identified School. I understand that the Athlete’s likeness and name may be used and displayed by Parkview Sports Medicine on its website and on social media, such as Twitter. I understand that if the Athlete provides an interview, information provided in the interview may also be included on the Parkview Sports Medicine website or on social media. I hereby release Parkview Sports Medicine, its employees and affiliates from any and all liability, claims, demands and causes of action connected with the use and publication of the Athlete’s likeness and other identifying information on the Parkview Sports Medicine website and social media.

Parent/Guardian Signature_________________________ Date_________________________

Student Signature_________________________ Date_________________________
Authorization for Release of Medical Information

I hereby authorize Parkview Ortho Performance Center d/b/a Parkview Sports Medicine, its physicians and providers ("PSM") to release any and all information regarding medical treatment provided to __________________________ (Student Name) related to any injury, illness or that otherwise concerns my physical condition and ability to participate in athletics at __________________________ (School Name). PSM may disclose the information to the School, its administration, coaching and athletic staff for the purpose of informing them of my playing status. I expressly authorize PSM to discuss my condition with these individuals.

If I am over 18: I also authorize PSM to release my medical information to my parent(s)/guardian(s).

I understand that I may revoke this authorization at any time by notifying PSM, in writing, of the revocation. The revocation will not affect any action already taken in reliance on this authorization. If not previously revoked, this authorization will terminate one (1) year from the earliest date set forth below.

I understand that information disclosed to the School, its administration, coaching and athletic staff pursuant to this authorization may be re-disclosed and no longer protected by federal privacy laws. PSM will not be responsible for any such further use or disclosure of the information.

I understand that PSM will not condition the provision of treatment, payment, enrollment in a health plan or eligibility for benefits on whether I sign this Authorization.

A photocopy of this authorization shall be considered as valid as the original.

Student Name ___________________________ Student Signature ___________________________

Student Address ___________________________

Date ___________________________

Parent/Guardian Name ___________________________ Parent/Guardian Signature ___________________________

Relationship to the Student ___________________________

Date ___________________________

You Are Entitled To A Copy Of This Authorization