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

Welcome to the University of Saint Francis! Parkview Sports Medicine is excited to provide your student-athlete with medical care while they are attending the University of Saint Francis. We look forward to providing the best quality care to your student-athlete while they are here.

Parkview Sports Medicine (PSM) is a division of Parkview Health and has a partnership with Ortho NorthEast. Parkview Sports Medicine not only provides your student-athlete and their team with athletic trainer coverage, but also many other services. PSM offers performance training, orthopedic care, sports nutrition, Parkview Athletic Rehab (PAR), care coordination, and a concussion clinic. Along with those services within Parkview Sports Medicine, PSM has access to other specialty services offered by Parkview Health.

At USF PSM provides four full time athletic trainers, in-house physical therapy five days a week from PAR therapists, and physician visits twice a week on campus. All care is coordinated by the athletic trainers at USF and our care navigation team at Parkview Sports Medicine.

Before your student-athlete can participate in any supervised athletic activities on campus they must complete a new student-athlete physical and attached paperwork. Along with this letter the packet includes the following that must be completed:

1. **USF New Student Athlete Information.**
   
   This form includes the student-athlete’s demographic information, Primary Insurance Information, Parent information, and Emergency Contact information.

2. **Student-Athlete Health Questionnaire and Athletic Physical Form**

   The student-athlete health questionnaire must be completed by the student-athlete prior to having their physician complete their physical. The sports medicine department does not require an immunization record on file. Student-athletes though may submit their immunization records to be kept in their file in the sports medicine department.

3. **University of Saint Francis Student-Athlete Concussion Statement and Informational Handout**

   All new student-athletes must read, complete and sign the student-athlete concussion statement before they are permitted to participate. By signing this document, the student-athlete acknowledges that they have read, understood, and will comply with USF’s concussion policy.

4. **Sudden Cardiac Arrest Fact Sheet**

   All new student-athletes must read the Sudden Cardiac Arrest Fact Sheet. Once read they must sign and date form acknowledging that they have read and understand this information. This will also be on file in the student-athlete’s file in the sports medicine department.
5. Parkview Sports Medicine Consent to treat, Notice of Privacy, Release of Medical information, and Media Release form

This form must be read by the student-athlete. Once read the student athlete is required to sign and date, acknowledging that they have read and understand this document. This form authorizes Parkview Sports Medicine to treat your student-athlete, protect their information, and gives Parkview Sports Medicines media department permission to interview and use all photos and videos of your student-athlete.

This packet must be completed and on file with the athletic trainer assigned to your son/daughter’s sport before their first schedule team supervised activity. Failure to do so will make them ineligible to participate in supervised team activities.

All student athletes are required to provide their primary insurance information and a copy of their insurance card. All student athletes are required to have their own primary insurance on file before being cleared for athletic participation. If a student athlete is unable to provide proof of primary insurance coverage there is a policy available for purchase through the school’s secondary insurance provider. Please contact your team’s athletic trainer for information.

If your student-athlete has any athletic related injuries during their time at USF, they should inform their athletic trainer immediately. This allows the sports medicine staff to properly care for and treat the injury. If any injury occurs that requires evaluation by one of our orthopedic physicians, we will coordinate with care navigation and team physicians to schedule that appointment.

All physician visits, diagnostics, and treatment not provided at USF along with physical therapy services provided for athletic related injuries will be billed to your student-athlete’s primary insurance first. The university’s secondary insurance will then be applied to remainder of bill. The secondary insurance policy will only cover those injuries that occur during supervised team activities, practices, and games. All non-athletic related injuries and illnesses are the student-athlete’s responsibility and will not be covered by the school's secondary insurance.

Once an athletic related injury occurs your student-athlete will complete a claim form with his/her athletic trainer. The claim form will then be submitted to the insurance company. If you or your student-athlete receives a bill from a provider, it is the responsibility of the student-athlete to provide that bill to their athletic trainer so the bill can be processed correctly. Ultimately, payment for all medical bills is the responsibility of the student-athlete. Please make sure that your student athlete is communicating with the sports medicine staff all bills that have not been processed by the school’s secondary insurance.

If you have any questions regarding the insurance process, please contact your student-athlete’s athletic trainer. Also, the school’s secondary policy does cover prescription drugs. If your student-athlete is prescribed a medication they will need to submit their receipt and all documents that come with prescription from their pharmacy to their athletic trainer. Their athletic trainer will make sure that all documentation for the prescription is submitted for reimbursement.
The NAIA does not permit the University of Saint Francis or any of its other institutions to pay medical expenses related to "illness", "conditions", or injuries which were not sustained as the direct result of an accident during a USF intercollegiate sport. All treatments will be performed in one of USF's athletic training rooms or at a Parkview facility as needed.

We hope your student-athlete has a healthy and successful career while at the University of Saint Francis. If you have any questions or concerns, please feel free to contact your son/daughter's athletic trainer.

Go Cougars!

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Cell: (260) 413-0428  
Email: jareinking@sf.edu

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Email: zruble@sf.edu

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Office: (260) 399-7700 x6208  
Cell: (260) 415-8689  
Email: jpatton@sf.edu

Drew Hollman, MS, LAT, ATC  
Office: (260) 399-7700 x6208  
Cell: (260) 450-7934  
Email: dhollman@sf.edu
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: __________________________
Physical

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

**FEMALES ONLY**

<table>
<thead>
<tr>
<th>Question</th>
<th>Y / N</th>
</tr>
</thead>
<tbody>
<tr>
<td>57. Have you ever had a menstrual period?</td>
<td></td>
</tr>
<tr>
<td>58. How old were you when you had your first menstrual period?</td>
<td></td>
</tr>
<tr>
<td>59. How many menstrual periods have you had in the last year?</td>
<td></td>
</tr>
</tbody>
</table>

**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 alcohol, 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-</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>arched palate, pectus excavatum,</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>arachnodactyly, arm span &gt; height,</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>hypertrophy, myopia, MVP, aortic</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>insufficiency)</td>
<td></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>Y / N</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>
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<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>
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<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>
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<tr>
<td>Foot/Toes</td>
<td>Y / N</td>
<td></td>
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<tr>
<td>Functional (Single Leg Hop or Squat, Box</td>
<td>Y / N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drop)</td>
<td></td>
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</tbody>
</table>

Notes: ____________________________________________________________

______________________________________________________________

__________________________  Cleared for Participation
__________________________  Restricted Participation
__________________________  May Not Participate

Physician Signature: ____________________________________________ Date: _____
CONCUSSION
A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?
A concussion is a brain injury that:
• Is caused by a blow to the head or body.
  • From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
  • Can change the way your brain normally works.
  • Can range from mild to severe.
  • Presents itself differently for each athlete.
  • 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 sticks 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 blurry 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).
• Slurred 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.

SPs 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 and 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
Athlete's Printed Name

Printed Name of Parent or Guardian

Street Address

Street Address

City, State, Zip

City, State, Zip

Phone Number

Email Address

Phone Number

Email Address

Consent to Treat and Provide Athletic Training and Sports Performance Services

I hereby authorize the athletic trainers, physicians, and qualified providers of Parkview Sports Medicine ("PSM") to provide athletic training, and to evaluate and/or provide medical treatment, within the scope of their practices, to the athlete named above. In the event the athlete is injured, PSM will make reasonable efforts to contact a family member at this number: ____________________________ if additional evaluation, treatment, or information is needed. I understand that PSM does not obtain prior insurance pre-certification or authorization and that I will be responsible for obtaining such authorization or pre-certification, if necessary.

Authorization for Release of Medical Information

I hereby authorize the athletic trainers, physicians, and qualified providers of PSM to release any and all information regarding my injury, illness, or physical condition, to the extent necessary, to determine my ability to participate in athletics at ____________________________ (School or Club Name). PSM may disclose the information to the School or Club, 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 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 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, or eligibility for benefits on whether I approve the release of my medical information. If I do not agree to release my medical information, I will strike this paragraph (cross it out).

Interview/Photographic Release

I hereby authorize PSM and its employees to interview, photograph, and videotape the athlete named above while participating in athletic events, practices, and other functions associated with athletics Club or School named above. I understand that the Athlete's likeness or name may be used and displayed by PSM on its website and on social media. I understand that if the Athlete provides an interview, information provided in the interview may also be included on the PSM 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 identifying information on the PSM website and social media. If I do not agree to this Release, I will strike it (cross it out).
Acknowledgement of Receipt or Declination of Notice of Privacy Practices

I acknowledge PSM has offered me a copy of its Notice of Privacy Practices ("Notice"). The Notice describes how PSM 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. My signature, below, indicates that I have either been offered or 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 or by calling PSM and requesting a copy of the Notice be mailed to me.

Release and Waiver of Liability for Athletic Training and Sports Performance Services

I voluntarily accept and assume all risk of participating in the athletic training and receiving sport performance services of PSM. I understand that such activities may expose me to associated risks of injury or even death, and I accept such risks.

I understand and acknowledge that I will engage in various physical activities designed to promote fitness. I hereby confirm that I have consulted with a duly licensed physician and have described to such physician the type of fitness program I am to participate in and have such physician’s approval to participate. I further understand that any questions or concerns that I may have related to my ability to participate in physical activities should be discussed with my physician prior to participation.

As a condition of participation, I agree to hold PSM, its affiliates, assigns, officers, employees, directors, agents, licensees, consultants and independent contractors harmless of any liability resulting from any injury or other harm that may occur in, result from, or arise out of participation in such fitness activities, including any bodily injury or other harm that may result from PSM’s own negligence.

Marketing Materials

I hereby consent to receive communication from PSM regarding its services, including marketing/promotional.

I HAVE READ AND UNDERSTOOD THIS TWO-PAGE AGREEMENT IN ITS ENTIRETY. I HAVE CROSSED OUT ANY TERMS WITH WHICH I CANNOT AGREE. I UNDERSTAND THAT BY MAKING AND SIGNING THIS AGREEMENT, I SURRENDER AND HEREBY WAIVE VALUABLE RIGHTS THAT I MAY HAVE, INCLUDING, BUT NOT LIMITED TO, MY RIGHT TO SUE. I DO SO FREELY AND VOLUNTARILY.

Printed Name of Athlete if 18 or over or Parent or Guardian (if Athlete is under 18)

__________________________________________

Signature of Athlete if 18 or over or Parent or Guardian (if Athlete is under 18)

__________________________________________

Date

__________________________

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