

Pre-Participation Physical Consent and HIPAA Acknowledgment

Patient Name (Print): _____ Date of Birth: _____ Phone #: _____

Sport(s): _____

Please list School(s)/Organization(s) to receive Medical Eligibility Form:

Pre-participation physical examinations are a recommended screening tool to identify conditions that might predispose an athlete to injury, illness or sudden death. If this screening concludes that additional follow-up and medical testing needs to be done to ensure the safety of your athlete, your athlete will not be cleared to participate. Full clearance will then need to be obtained with a specialist and/or a primary care doctor. Additionally, we would like to share the eligibility results of the pre-participation physical examination with your athlete's sport organization(s). Please sign and return the below waiver so that we may perform the physical exam screening and communicate the medical eligibility form with the necessary sport organization(s). Please call Brandie Martin ATC, if you have any questions at (970) 479-5865.

Consent to Treat

I hereby give consent/permission to the sports medicine staff and participating licensed medical providers acting on behalf of The Steadman Clinic to perform a pre-participation screening physical examination for myself/child. This includes any and all reasonable and necessary physical exams for screening of body systems, preventative care, treatment, and rehabilitation for these injuries/illnesses. I agree that this screening exam is only a limited screening examination and does not take the place of a complete medical examination. I understand and agree that the medical provider(s) completing the screening exam shall not be responsible for any ongoing medical care or treatment for any medical condition or for injuries that occur after the screening exam. I represent, to the best of my knowledge, that my child has no known medical condition that would prevent participation in sports. I agree to follow up with my child's primary care provider or specialist in the event that any medical condition is identified in the screening exam.

I understand and agree that if I/my child experience an injury/illness or change in my/their health status it is my responsibility to inform my/their primary care doctor. I also agree to adhere to the established injury management guidelines including rehabilitation and reassessment before I am released to return to full participation.

This authorization expires one (1) year from the date signed.

Printed Name Date

Signature Parent/Guardian Signature (if patient is under 18 years of age)

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I received the Steadman Clinic's Notice of Privacy Practices.

Signature Patient or Parent/Guardian (if under 18 years old) Date

CONSENT TO RELEASE MEDICAL INFORMATION

I hereby give consent for The Steadman Clinic to communicate my child's pertinent medical information obtained in the pre-participation physical examination to his/her school/sport organization(s) and medical services providers as appropriate to safeguard his/her physical well-being. A copy of the physical examination and history form will be kept on file at The Steadman Clinic's Athletic Training Office.

Signature (Parent/Guardian Signature if student-athlete is under 18 years of age) Date

Waiver valid one year from date of signature