Pre-Participation Physical Consent and HIPAA Acknowledgment

Athletes Name (Print): _____ **Date of Birth:** _____

Phone Number: _____ **Sport:** _____

The Steadman Clinic's medical staff is concerned with your athlete's health and success. 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 and a completed and a signed letter of clearance to participate in sports/activity will need to be done. Additionally, we would like to share the results of the pre-participation physical examination with your athlete's sport organization. Please sign and return the below waiver so that we can communicate the pre-participation physical examination form with the necessary sport organization. Please call Brandie Martin ATC, if you have any questions at (970) 479-5865.

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 sport organization(s) and medical services providers as appropriate to safeguard his/her physical well-being.

_____Date _____

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

Waiver valid one year from date of signature

Consent to Treat

I hereby authorize the sports medicine staff acting on behalf of The Steadman Clinic to evaluate and treat any injury/illness during the pre-participation physical examination. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses.

I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my 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 student-athlete is under 18 years of age)

_____

Acknowledgement of Notice of Privacy Practices

Name of Student/Patient (please print): _____ Date of Birth: _____

I hereby acknowledge that I received the Steadman Clinic´s Notice of Privacy Practices (Attached document)

Signature of athlete or parent/guardian:_____ Date_____