Fall 2015

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than May 30th and shall be effective, regardless of when performed during a school year, until the next May 31st.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/_____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address _____

Current Home Phone # ( )_____ Parent/Guardian Current Cellular Phone # ( )_____

Fall Sport(s): _____ Winter Sport(s): _____ Spring Sport(s): _____

EMERGENCY INFORMATION

Parent's/Guardian's Name_____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Medical Insurance Carrier_____ Policy Number_____

Address _____Telephone # ( ) _____

Family Physician's Name_____, MD or DO (circle one)

Address _____Telephone # ( ) _____

Student's Allergies_____

Student's Health Condition(s) of Which an Emergency Physician Should be Aware_____

_____

_____

_____

Student's Prescription Medications_____

_____

* Please turn forms in with all page numbers in order →

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____ Date____/____/_____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature _____ Date____/____/_____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____ Date____/____/_____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care.

Parent's/Guardian's Signature _____ Date____/____/_____

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?
A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?
Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  The right equipment for the sport, position, or activity;
  Worn correctly and the correct size and fit; and
  Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____ Date____/____/_____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature _____ Date____/____/_____

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

_____ _____ Date____/____/_____

Signature of Student-Athlete | Print Student-Athlete's Name

_____ _____ Date____/____/_____

Signature of Parent/Guardian | Print Parent/Guardian's Name

Student's Name _____ Age_____ Grade_____

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐
	Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes		
20.	Have you ever had a stress fracture?	☐	☐
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐
22.	Do you regularly use a brace or assistive device?	☐	☐

		Yes	No
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐
25.	Is there anyone in your family who has asthma?	☐	☐
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐
27.	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐
30.	Have you ever had a herpes skin infection?	☐	☐
	CONCUSSION OR TRAUMATIC BRAIN INJURY		
31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐
33.	Do you experience dizziness and/or headaches with exercise?	☐	☐
34.	Have you ever had a seizure?	☐	☐
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐
39.	Have you had any problems with your eyes or vision?	☐	☐
40.	Do you wear glasses or contact lenses?	☐	☐
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐
42.	Are you unhappy with your weight?	☐	☐
43.	Are you trying to gain or lose weight?	☐	☐
44.	Has anyone recommended you change your weight or eating habits?	☐	☐
45.	Do you limit or carefully control what you eat?	☐	☐
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐
	FEMALES ONLY	☐	☐
47.	Have you ever had a menstrual period?	☐	☐
48.	How old were you when you had your first menstrual period?	_____	
49.	How many periods have you had in the last 12 months?	_____	
50.	Are you pregnant?	☐	☐

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date____/____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date____/____/_____

5 of 11

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____

Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SNP *(circle one)* Authorized Date of CIPPE ___/___/___

6 of 11

Section 8: Re-Certification by Licensed Physician of Medicine or Osteopathic Medicine

This Form must be completed for any student who, subsequent to completion of Sections 1 through 6 of this CIPPE Form, required medical treatment from a licensed physician of medicine or osteopathic medicine. This Section 8 may be completed at any time following completion of such medical treatment. Upon completion, the Form must be turned in to the Principal, or the Principal's designee, of the student's school, who, pursuant to ARTICLE X, LOCAL MANAGEMENT AND CONTROL, Section 2, Powers and Duties of Principal, subsection C, of the PIAA Constitution, shall "exclude any contestant who has suffered serious illness or injury until that contestant is pronounced physically fit by the school's licensed physician of medicine or osteopathic medicine, or if none is employed, by another licensed physician of medicine or osteopathic medicine."

NOTE: The physician completing this Form must first review Sections 5 and 6 of the herein named student's previously completed CIPPE Form. Section 7 must also be reviewed if both (1) this Form is being used by the herein named student to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in a subsequent sport season in the same school year AND (2) the herein named student either checked yes or circled any Supplemental Health History questions in Section 7.

If the physician completing this Form is clearing the herein named student subsequent to that student sustaining a concussion or traumatic brain injury, that physician must be sufficiently familiar with current concussion management such that the physician can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered by that physician.

Student's Name: _____ Age_____Grade_____

Enrolled in _____School

Condition(s) Treated Since Completion of the Herein Named Student's CIPPE Form: _____

_____

_____

_____

_____

A. GENERAL CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with no restrictions, except those, if any, set forth in Section 6 of that student's CIPPE Form.

Physician's Name (print/type)_____ License #_____

Address_____ Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____

B. LIMITED CLEARANCE: Absent any illness and/or injury, which requires medical treatment, subsequent to the date set forth below, I hereby authorize the above-identified student to participate for the remainder of the current school year in additional interscholastic athletics with, in addition to the restrictions, if any, set forth in Section 6 of that student's CIPPE Form, the following limitations/restrictions:

1. _____
2. _____
3. _____
4. _____

Physician's Name (print/type)_____ License #_____

Address_____ Phone ( )_____

Physician's Signature _____MD or DO *(circle one)* Date_____

BALDWIN-WHITEHALL SCHOOL DISTRICT

INSURANCE WAIVER & RELEASE FORM

Dear Parent/Guardian,

Your child has indicated an interest in participating in the Baldwin-Whitehall School District Athletic Program. We know that it is your will as well as ours that every possible precaution be taken to protect our students from injury. We do our utmost to promote this by proper training, by the use of good protective equipment, by supervising all activities, and by encouraging good safety habits.

Despite all our efforts, accidents do happen occasionally in athletics as elsewhere. The school is not legally liable for medical or hospital expenses, damages related to pain and suffering, loss of earning capacity or any other expenses or damages resulting from athletic injuries incurred in interscholastic sports/activities.

We the undersigned parent or guardian, intending to be legally bound, do hereby release, discharge, and waive the Baldwin-Whitehall School District from any liability for any injury to our child resulting from any cause whatsoever in connection with our child participating in a Baldwin-Whitehall School District Athletic Program(s) or any other interscholastic activity. We further hereby agree to indemnify and hold harmless the Baldwin-Whitehall School District from any expenses that we may incur in connection with the participation of our child in the above mentioned activity.

Warning and Notification of Risk

Playing, practicing or participating in a sport can be a dangerous activity involving risk of injury. There is no limitation to the nature or severity of the possible injuries in some sports. Some sports injuries can result in serious permanent impairment or be life threatening. Unfortunately, injury may occur simply due to the nature of the sport/activity without the occurrence of any unusual event and without fault.

I have read the above WARNING. I am aware and understand the risks of practicing, participating in and playing interscholastic activities. I recognize the importance of following the coaches' instructions regarding the activity.

Signature of Student _____ Date_____

We are the parents/legal guardian of the above named student. We have read the Insurance Waiver and Release, as well as the Warning and Notification of Risk and understand the risks of our child participating in interscholastic activities.

Signature of Parent/Guardian _____ Date_____

_____ This is to acknowledge that my child is adequately covered by our own personal insurance against injuries sustained in interscholastic athletics. He/she has my permission to participate in

_____.

Signature of Parent/Guardian _____ Date_____

5 of 11

BALDWIN-WHITEHALL SCHOOL DISTRICT
ATHLETIC OFFICE
4653 Clairton Boulevard
Pittsburgh PA 15236

_____ _____
Sport **Grade & Section**

Seasons of interscholastic competition in this sport beyond the 6th grade including the present season. Put an x in the appropriate column:

7th	8th	9th	10th	11th	12th

_____ _____ _____
Student's Name **Date of Birth** **Age**

_____ _____
Address **Zip Code**

_____ _____
Home Phone Number **Parents' Work Phone or Cell Phone Numbers**

Have you attended school anywhere other than in the Baldwin-Whitehall School District in the past three months (including summer school)? _____ If so, where: _____
_____.

NCAA: If your son or daughter intends to participate in Division I or II College athletics as a freshman, he or she must register with and be certified by the NCAA Initial-Eligibility Clearinghouse. Please sign below indicating your awareness of this requirement. Registration materials can be obtained in the Guidance Office.

_____
Signature Parent/Guardian
Parent/Guardian of All Students Must Sign

ATHLETE'S AGREEMENT

I agree to assume full responsibility for all athletic equipment issued to me and agree to return all of it according to regulations. I agree to use every care to keep my "equipment account" straight and to confine the use of my equipment to the regularly scheduled school practices, games or meets and not to wear it at other times.

I understand that as a member of or a candidate for an athletic team I am officially representing my school and all of its standards and ideals. Any action on my part that will render me unworthy of that honor will result in my temporary or permanent separation from the activity.

_____ _____
DATE ***SIGNATURE OF STUDENT***

Allegheny Health Network

Sports Medicine

Patient Name: _____ Date: _____

Date of Birth: (xx/xx/xxxx) : _____ Last 4 (Four) digits of SSN: _____

Address: _____

Phone Number: _____ Fax Number: _____

Authorization for Release of Protected Health Information

I hereby authorize the West Penn Allegheny Health System, Inc. – Allegheny General Hospital certified athletic trainer(s) and team physician(s) to release my Protected Health Information (PHI):

Please choose who will receive the information and the method of delivery. Be certain that information is accurate and complete. Incomplete authorizations are invalid.

☐ School Administration, Athletic Directors, Secretaries, Nurses and Coaches (if student), and parent (if student is 18 or older):

The PHI I would like to have released is as follows:

☐ Release my entire chart (I understand that information may include acquired immunodeficiency syndrome (AIDS) or infection with human immunodeficiency virus; mental health care; treatment for alcohol and/or drug abuse; and sexually transmitted disease unless otherwise indicated).

Do not release: ☐ **AIDS/HIV** ☐ **Mental Health History** ☐ **Drug & Alcohol**

☐ Other (specifically identify exact information to be disclosed, including specific dates of service):

_____

- I understand that this Authorization shall expire one (1) year from the date of signature unless otherwise specified below.
- I understand that I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to the healthcare provider at which this Authorization was executed. Such revocation will be effective upon receipt, except to the extent that the recipient has already taken action in reliance on this Authorization.
- I understand that I am not required to sign this Authorization as condition of my obtaining treatment.
- I understand that, to extent that any recipient of this information, as identified above, is not a "covered entity" under Federal Law, the information may no longer be protected by federal and state law. I understand that, in these circumstances, the individual receiving this information may be permitted to re-disclose the information. I understand that my healthcare provider is not responsible should the individual receiving this information re-disclose the information.
- I am entitled to a copy of this completed Authorization upon my request.
- I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent, Legal Guardian or Authorized Representative Date

Witness/Staff Member Signature _____ Date _____

If signed by an Authorized Representative, complete the following:
Printed Name of Personal Representative: _____
Description of Authority to act for individual: _____

Oral Authorization
Only to be used if patient is physically unable to sign. This is NOT applicable to HIV related information or Drug & Alcohol Treatment.
I witness that the nature of this release has been explained to the patient, that the patient understood the nature of the release and freely gave oral authorization (two witnesses are required).
Witness: _____ Witness: _____
Date: _____ Date: _____

Allegheny
Health Network

Sports Medicine

Authorization for Consent of Treatment, by Licensed Athletic Trainer(s)/Team Physicians, Within the Scope of Practice

I, _____ (printed name of parent, legally authorized representative, or athlete if over 18) hereby authorize West Penn Allegheny Health System, Inc. – Allegheny General Hospital (AGH)Certified Athletic Trainer(s)/Team Physicians to provide only those services they are qualified through education or experience and which is allowed by their practice acts and other pertinent regulation.

This authorization is valid for 1 calendar year from the date below.

I understand that this authorization is subject to revocation at any time, except to the extent that West Penn Allegheny Health System, Inc. – Allegheny General Hospital has already taken action in reliance upon it. A photocopy or facsimile of this authorization will be considered valid unless otherwise specified. I also understand and agree that this authorization will terminate as set forth above unless I revoke this authorization in writing to AGH (1307 Federal Street, Suite 500, Pittsburgh, PA 15212).

_____
Parent, Guardian, or Athlete (if over 18) Signature Date Witness