LITTLE ROCK CHRISTIAN HIPPA FORM

AUTHORIZATION FOR USE OF DISCLOSURE OF HEALTH INFORMATION (HP 6.0.F3)

I _____hereby authorize the use and disclosure of individually
(Printed name of parent/guardian)
identifiable health information relating to my minor child,_____
(Printed name of minor child)
which is called "Protected Health Information" under a federal health privacy law, as described below:

Initial each section

A. The "Protected Health Information" (P.H.I.) will include but is not limited to preparticipation physical evaluation, evaluation information, and rehabilitation information. The P.H.I. can be in the form of a personal conversation and /or written report.
   Please Initial:_____
B. The primary care physician, team physician, and certified athletic trainer will be authorized to use or disclose the "Minor Child's" health information (P.H.I.) Please initial:
C. The coaching staff, athletic director, and administration personal will be authorized to obtain health information (P.H.I.) from the above persons. Please initial: _____

   The health information (P.H.I.) will be used and/or disclosed for the purpose of this ability to provide accurate and complete medical coverage for the "Minor Child".

Please indicate if any part of the "Minor child's" health information (P.H.I.) should be excluded and I or authorized personal described above should be excluded from using the "Minor Child's health information (P.H.I.).

_____

_____

- I understand that if the person or entity that receives this information is not a health plan or health care provider covered by federal privacy regulation, the released information may be re- disclosed by the recipient and may no longer be protected by federal or state law.
- I understand that I may revoke this authorization at any time by notifying Martin Knee and Sports Medicine in writing. However, if I choose to do so, I understand that my revocation will not affect any action taken by Martin Knee and Sports Medicine before receiving my revocation.
- I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, and enrollment in a health plan, or eligibility for benefits.

_____ _____
Signature of Parent/Guardian *Date*

_____ _____
Signature of Parent/Guardian *Date*

Basis of authority to act for the minor child: _____

This authorization expires on: _____/ _____/ _____ (one year anniversary)

LITTLE ROCK CHRISTIAN ACADEMY
ATHLETIC HEALTH EXAM 2021-2022

Name: _____ **2021-2022 Grade:** _____ Gender: M F Exam Date:_____

Birthday: _____/_____/_____ Sport(s) participating in: _____

Address: _____ Phone: _____

Family Physician: _____ Phone: _____

In emergency, contact: Name _____

Relationship: _____ Home # _____ Work # _____ Cell #_____

Dates of last shot: Tetanus: _____; Hepatitis B: _____; Measles: _____; Chickenpox:_____

EMERGENCY INFORMATION

Allergies _____

_____

TO BE FILLED OUT BY PHYSICIAN

Height: _____ Weight: _____ B/P: _____/_____ Pulse: _____ Resp.: _____

Vision: R 20/_____ L 20/_____ Corrected: Y N Pupils: Equal ____ Unequal _____

Please complete the Health History on reverse side

CHECK ALL THAT APPLY, SIGN AND DATE:

_____ I authorize the School Staff and Trainer of Little Rock Christian Academy to administerTylenol/Advil to my child as needed.

_____ I hereby consent for the above student to represent Little Rock Christian Academy in interscholastic activities.

_____ I give my consent for him/her to accompany the team as a member on out-of-town trips and will not hold Little Rock Christian Academy responsible in case of injury or accident.

_____ I give my consent and authorize Little Rock Christian Academy to obtain, through a physician of its choice, such medical care as is reasonable necessary for the welfare of the student, if he/she is injured in the course of school athletic activities or unforeseen accident.

_____ _____

Signature of Parent or Guardian Date

Physical Evaluation by: Physician/Clinic _____

Address: _____ Phone: _____

_____

Signature of Doctor

_____ _____

Please Print Name Date

EXPLAIN "YES" ANSWERS IN SPACE ON RIGHT.

HEALTH HISTORY:	YES	NO
1. Have you ever had a medical illness or injury since your last check up?		
Do you have ongoing or chronic illness?		
2. Have you ever been hospitalized overnight?		
Have you ever had surgery?		
3. Are you currently taking any prescription or nonprescription (over the counter) medications, pills or using an inhaler?		
Have you ever taken any supplements or vitamins to help you gain or lose weight or improve your performance?		
4. Do you have allergies? (i.e. pollen, medicine, food, or insects bite)		
Have you ever had a rash or hives develop during or after exercise?		
5. Have you ever passed out during or after exercise?		
Have you ever been dizzy during or after exercise?		
Have you ever had chest pain during or after exercise:		
Have you ever had racing of your heart or skipped heartbeats?		
Do you get tired more quickly than your friends do during exercise?		
Have you ever had high blood pressure or high cholesterol?		
Have you ever been told you have a heart murmur?		
Has any family member or relative died of heart problems or of sudden death before age 50?		
Have you had a severe viral infection (i.e. myocarditis or mononucleosis) within the last month?		
Has a physician ever denied or restricted your participation in sports for any heart problems?		
6. Do you have any current skin problems? (i.e. itching, rash, acne, warts, fungus or blisters)		
7. Have you ever had a head injury or concussion?		
Have you ever been knocked out, become unconscious or lost memory?		
Have you ever had a seizure?		
Do you have frequent or severe headaches?		
Have you ever had numbness or tingling in your arms, legs, hands or feet?		
Have you ever had a stinger, burner or pinched nerve?		
8. Have you ever become ill from exercising in the heat?		
9. Do you cough, wheeze or have trouble breathing during or after activity?		
Do you have asthma?		
Do you have seasonal allergies that require medical treatment?		
10. Do you use any special protective or corrective equipment or devices that aren't usually used for your sport or position? (i.e. knee brace, neck roll, foot orthotics, retainer on teeth, hearing aid)		
11. Have you had any problems with your eyes or vision?		
Do you wear glasses, contacts, or protective eyewear?		
12. Have you ever had a sprain, strain, or swelling after injury?		
Have you broken or fractured any bones or dislocated any joints?		
Have you had any other problems with pain or swelling in muscles tendons, bones or joints? If yes, check box and explain: ❑ Head ❑ Elbow ❑ Hip ❑ Neck ❑ Knee ❑ Forearm ❑ Thigh ❑ Back ❑ Chest ❑ Ankle ❑ Hand ❑ Shin/calf ❑ Shoulder ❑ Finger ❑ Foot ❑ Upper arm ❑ Wrist		
13. Do you want to weigh more or less than you do now?		
Do you lose weight regularly to meet weight requirements for your sport?		
14. Do you feel stressed out?		
15. Have you ever been tested for sickle cell?		
If so, were results positive?		
16. Has a doctor ever denied or restricted your participation in sports for any reason?		
FEMALES ONLY — 17. Have you ever had a menstrual period?		
18. How old were you when you had your first period?		
19. How many periods have you had in the last 12 months?		

Explain "Yes" answers here: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

FOR PHYSICIAN USE ONLY

	Normal	Abnormal
Eyes		
Ears, Nose, Throat		
Lymph Nodes		
Heart		
Pulses		
Lungs		
Abdomen		
Musculoskeletal: ROM, Strength		
Neck/Spine		
Shoulders		
Elbow/Arms		
Wrist/Hands		
Hips/Thighs		
Knees		
Legs/Ankles		
Feet		

❑ Cleared for all sports without restriction

❑ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

❑ Not cleared

❑ Pending further evaluation

❑ For any sports

❑ For any sports_____

_____

Reasons_____

_____

Recommendations _____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.

_____ _____

Athlete Signature Parent Signature