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 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 LRCA's Trainer, Scott Caldwell. However, if I choose to do so, I understand that my revocation will not affect any action taken by Trainer, Scott Caldwell 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.

_____ _____ _____
Signature of Parent/Guardian Date

_____ _____
Printed name of Parent/Guardian Date

■ PREPARTICIPATION PHYSICAL EVALUATION

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

EXAMINATION		
Height: Weight:		
BP: / (/) Pulse: Vision: R 20/ L 20/ Corrected: □ Y □ N		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal, hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), methicillin-resistant *Staphylococcus aureus* (MRSA), ortinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

*Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings

☐ **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 certain sports** _____

Reason: _____

Recommendations: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of provider: _____ Date of exam: _____

Address: _____ Phone: _____

Signature of physician, APN, PA: _____

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM- Page 1

ARKANSAS ACTIVITIES ASSOCIATION

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name:_____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth _____

Have you had COVID-19?: ☐ Yes ☐ No

Have you been immunized for COVID-19?: ☐ Yes ☐ No

If yes, you have had: ☐ One shot ☐ Two shots

List past and current medical conditions:

_____

Have you ever had surgery? If yes, list all past surgical procedures:

_____

Medicines and supplements- List all current medications, over-the-counter medicines, and supplements (herbal and nutritional):

_____

Do you have any allergies? If yes, list all of your allergies (ie medicines, pollens, food, stinging insects):

_____

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?		
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?		
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?		

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM- Page 2

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease?		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?		
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

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

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

Arkansas Activities Association
Sports Medicine Fact Sheet for Parents and Students

This document has been created by the Arkansas Activities Association Sports Medicine Advisory Committee. The committee's mission is to ensure Arkansas Activities Association member schools provide sound and consistent medical information to enhance the safety of their athletic programs. The AAA Sports Medicine Committee is committed to offering information and guidance to member schools on topics which impact the welfare of all those involved in interscholastic competition. The topics included in this fact sheet are: Exertional Heat Stroke, MRSA, Concussion, and Sudden Cardiac Arrest. The following pages contain important sports medicine information for parents and students. Please read the information and sign to acknowledge that you have received and reviewed the information.

Arkansas Activities Association
Exertional Heat Stroke Facts

WHAT IS EXERTIONAL HEAT STROKE

Heat stroke is a severe heat illness that occurs when a child's body creates more heat than it can release, due to the strain of exercising. This results in a rapid increase in core body temperature, which can lead to permanent disability or even death if left untreated.

WHAT ARE THE SIGNS AND SYMPTOMS OF HEAT STROKE

- Increase in core body temperature, usually above 104*F/40*C (rectal temperature)
- Central nervous system dysfunction, such as altered consciousness, seizures, confusion, emotional instability, irrational behavior or decreased mental acuity.
- Nausea, vomiting, diarrhea
- Headache, dizziness or weakness
- Hot and wet or dry skin
- Increased heart rate, decreased blood pressure or fast breathing
- Dehydration
- Combativeness

TREATMENT

- Locate medical personnel immediately. Remove extra clothing or equipment. Begin aggressively whole-body cooling by immersing in tub of cold water. If a tub is not available, use alternative cooling methods such as cold water fans, ice or cold towels (replaced frequently), placed over as much of the body as possible
- Call emergency medical services for transport to nearest emergency medical facility.

WHEN SHOULD I PLAY AGAIN?

No one who has suffered heat stroke should bee allowed to return until appropriate healthcare personnel approves and gives specific return to play instructions. Parents should work with medical professionals to rule out or treat any other conditions or illnesses that may cause continued problems with heat stroke. Return to physical activity should be done slowly, under the supervision of appropriate healthcare professionals.

Arkansas Activities Association
MRSA Facts

WHAT IS MRSA

MRSA is methicilliin-resistant Staphylococcus aureus, a potentially dangerous type of staph bacteria that is resistant to certain antibiotics and may cause skin and other infections. As with all regular staph infections, recognizing the signs and receiving treatment for MRSA skin infections in the early stages reduces the chances of the infection becoming severe. MRSA is spread by: having contact with another person's infections, sharing personal items such as towels or razors, that have touched infected skin, touching surfaces or items, such as used bandages, contaminated with MRSA.

WHAT ARE THE SIGNS AND SYMPTOMS MRSA

Most staph skin infections, including MRSA, appear as a bump or infected area on the skin that may be:

- Red
- Swollen
- Painful
- Warm to the touch
- Full of pus or other drainage
- Accompanied by fever.

WHAT IF I SUSPECT MRSA SKIN INFECTION

Cover the area with a bandage and contact your healthcare professional. It is especially important to contact your healthcare professional if signs and symptoms of an MRSA skin infections are accompanied by fever.

HOW ARE MRSA SKIN INFECTIONS TREATED

Treatment may include having a healthcare professional drain the infection and, in some cases, prescribe an antibiotic. Do not attempt to drain the infection yourself— doing so could worsen or spread it to others. If you are given an antibiotic, be sure to take all of the doses (even if the infection is getting better), unless your healthcare professional tells you to stop taking it.

HOW CAN I PROTECT MY FAMILY FROM MRSA SKIN INFECTIONS

- Know the signs and symptoms
- Get treated early
- Keep cuts and scrapes clean
- Encourage good hygene
- Clean hands regularly
- Discourage sharing personal items such as towels and razors.

FOR MORE INFORMATION, PLEASE CALL

1-800-CDC-INFO OR visit www.cdc.gov/MRSA

Arkansas Activities Association
Concussion Facts

WHAT IS A CONCUSSION

A concussion is an injury that changes how the cells in the brain normally work. A concussion is caused by a blow to the head or body that causes the brain to move rapidly inside the skull. Even a "ding," "getting your bell rung," or what seems to be mild bump or blow to the head can be serious. Concussions can also result from a fall or from players colliding with each other or with obstacles, such as a goalpost.

WHAT ARE THE SIGNS AND SYMPTOMS OF A CONCUSSION

Observed by the Athlete

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light
- Bothered by noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory Problems
- Confusion
- Does not "feel right"

Observed by the Parent / Guardian, Coach, or Teammate

- Is confused about assignment or position
- Forgets an instruction
- Is unsure of game, score, or opponent
- Moves clumsily
- Answers questions slowly
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Can't recall events after hit or fall
- Appears dazed or stunned

WHAT TO DO IF SIGNS/SYMPTOMS OF A CONCUSSION ARE PRESENT

Athlete

- TELL YOUR COACH IMMEDIATELY
- Inform parents
- Seek medical attention
- Give your self time to recover

Parent / Guardian

- Seek medical attention
- Keep your child out of play
- Discuss play to return to play with coach
- Address academic needs

WHERE CAN I FIND OUT MORE INFORMATION?

- Center for Disease Control
  www.cdc.gov/concussion/HeadUp/youth.html
- NFHS Free Concussion Course
  http://nfhslearn.com/electiveDetail.aspx?courseID=15000

RETURN TO PLAY GUIDELINES

1. Remove immediately from activity when signs/symptoms are present.
2. Release from medical professional required for return (Neuropsychologist, MD, DO, Nurse Practitioner, Certified Athletic Trainer, or Physician Assistant)
3. Follow school district's return to play guidelines and protocol

Arkansas Activities Association
Sudden Cardiac Facts

WHAT IS SUDDEN CARDIAC ARREST

Sudden cardiac arrest (SCA) is a condition in which the heart suddenly and unexpectedly stops beating. If this happens, blood stops flowing to the brain and other vital organs. The information presented below is to provide you with the knowledge you need to help the coach keep your child safe at practices and games.

WHAT ARE THE SIGNS AND SYMPTOMS OF SUDDEN CARDIAC ARREST

- Fainting or seizures during exercise
- Unexplained shortness of breath
- Chest pain
- Dizziness
- Racing heart beat
- Extreme fatigue

GUIDELINES FOR REMOVAL OF A STUDENT FROM ACTIVITY

- Every coach and registered volunteer must receive training every three years on prevention of sudden cardiac death.
- Every athlete and parent must read and sign the AAA Sports Medicine Fact Sheet containing information on sudden cardiac arrest.
- Any athlete experiencing syncope (fainting), chest pains, shortness of breath that is out of proportion to their level of activity or an irregular heart rate should not return to practice or play until evaluated by an appropriate healthcare professional (MD, DO, APN, Certified Athletic Trainer).
- The referred athlete must be medically cleared by an appropriate healthcare professional prior to return to play/practice.

SIGNATURES

By signing below, I acknowledge that I have received and reviewed the attached AAA Sports Medicine Fact Sheet for Athletes and Parents. I also acknowledge and I understand the risks of injuries associated with participation in school athletic activity.

_____	_____	_____
Athlete's Signature	Print Name	Date
_____	_____	_____
Parent / Guardian Signature	Print Name	Date