STEADMAN HAWKINS SPORTS MEDICINE SERVICES
CONSENT AND AUTHORIZATION

I, ________________________________, parent/legal guardian of ____________________________________, a student/participant at ______________________________ (the “School/Event”) authorize Prisma Health staff to provide my child any healthcare services offered by Steadman Hawkins Sports Medicine (“SHSM”) and to make appropriate referrals for my child to receive any additional health services that my child’s condition may indicate. To protect and improve the health of athletes, Prisma Health will provide athletic trainers to provide on-site treatment and consultation to student/participants. These services will be overseen by a physician serving as Medical Director for SHSM.

In addition, in the event my child needs urgent or emergency treatments off-site, I authorize staff of SHSM to arrange for such care, including appropriate transportation. I understand that SHSM staff will contact me as soon as possible in the event my child has an urgent or emergency condition. I agree to complete all health history, family history, and other informational requests necessary for my child’s participation in the SHSM program. I understand that I may contact the Athletic Trainer assigned to the School or the Medical Director for SHSM to discuss my child’s care or to discuss any questions I may have about the program. I consent to the release by Prisma Health/SHSM staff of information about my child’s medical condition obtained through SHSM Services to physicians, coaches, and other employees or agents of Prisma Health or to whom I am referred. I also consent to the release of information about my child’s medical condition to necessary staff at the school, should accommodations be needed to aid in my child’s education.

I understand that I will not be charged for services rendered on-site by the medical staff, but that I or my child’s insurance carrier may be charged for services rendered by other healthcare providers. I consent for information in my child’s medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize Prisma Health to submit claims for services rendered to my child and assign to Prisma Health my rights to any reimbursement for such services.

In consideration for the services provided to my child by SHSM, I hereby release Prisma Health, its trustees, officers, employees, and agents from and against any claim, liability, and cause of action or other expense arising out of the services provided by Prisma Health Sports Medicine Services.

I acknowledge, by signing below, that I have received a copy of the Prisma Health Notice of Privacy Practices.

I have read and understand the above information and consent to my child’s participation in Prisma Health Sports Medicine Services.

______________________________	______________________________
Name of Parent/Guardian (please print)	Signature of Parent/Guardian
______________________________	______________________________
Name of Student (First, Middle, Last)	Witness/Date

STEADMAN HAWKINS SPORTS MEDICINE

Athlete's Name______________________________ **DOB**___________ **SSN**_______________ **Grade**_____
(First / Middle / Last)

Gender ____Male ____Female **Ethnicity** ____ Hispanic/Latino ____ Not Hispanic/Latino

Race ___American Indian ___Asian ___Black/African American ___Caucasian ___Hawaiian ______________Other

Language(s) ____

School____ Sport(s) __________________________________

Guardian(s)___________________________________ **Phone #s (h)**________________________________

Relationship(s)_________________________________ **(c)**___________________________________

Address____
Street City State Zip

Guardian(s) Email__________________________________ Athlete's Email_____________________________

Emergency Contact______________________________**Phone #s (h)**_____________**(c)**______________
(Guardians will be contacted first in case of emergency, please list another individual)

Insurance Carrier ___________________________ HMO/PPO **Group /Policy #**________________________
(circle one)

Insurance Preferred Network/Provider: **yes/no** (circle one) Whom __________________________________

Does your child have any of the following? (list details as appropriate)

		Yes	No
Asthma	____________________________________	[ ]	[ ]
Inhaler	____________________________________	[ ]	[ ]
Heart Condition	____________________________________	[ ]	[ ]
Vision Loss	____________________________________	[ ]	[ ]
Epilepsy	____________________________________	[ ]	[ ]
Diabetes	____________________________________	[ ]	[ ]
Kidney Condition	____________________________________	[ ]	[ ]
Hearing Loss	____________________________________	[ ]	[ ]
Allergies	____________________________________	[ ]	[ ]
Medication Allergy	____________________________________	[ ]	[ ]
Severe Headaches	____________________________________	[ ]	[ ]
Sickle Cell	____________________________________	[ ]	[ ]

Previous injuries/surgeries (month/year) ____
____

Is your child on medication, taken regularly? (List ALL) ____
____

Family primary care physician: Name _____________________________ Phone______________________
Family orthopedic physician: Name______________________________ Phone______________________

My child may take any over-the-counter medication such as Tylenol® / Advil® YES NO

_____________________________________ ____________________________

Parent/Guardian Signature Date