ATHLETE AUTHORIZATION TO RELEASE INFORMATION

The content of my medical record is confidential and protected under state and federal law as per the HIPAA Notice of Privacy Practice posted in the school athletic training room. I understand that in an effort to provide quality athletic training services and maintain my safety, it is imperative that the athletic trainer for Lezzer Lumber Football Classic, who is employed by Drayer Physical Therapy Institute (DPTI), and any other DPTI employee who assists the athletic trainer with my care, keep other Lezzer Lumber Football Classic personnel informed, on a need to know basis, of my health care status and pertinent health care needs related to my participation in the game.

Therefore, I, or my parent/legal guardian, hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive this information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Student Athlete's Name: [Print] _____ **Date of Birth:** _____

Organization Providing the Information: DRAYER PHYSICAL THERAPY INSTITUTE

Organization(s) or Person(s) Receiving the Information: Head Coach, Assistant Coach(es), Team Physician, Equipment Manager, Representatives from Lezzer Lumber Football Classic.,

Other:_____

Specific Description of Information Disclosed: √ Athletic Training Medical Record

Purpose of Disclosure: Coordination of Athlete's Athletic Training and Medical Services in conjunction with participation in The Lezzer Lumber Football Classic and related activities.

This Authorization is not for marketing purposes.

By signing and initialing the following statements, I authorize the release of such information to the persons listed above.

1. I understand this Authorization will expire one year from the date of signature or on the following event: Termination of the student athlete/athletic trainer relationship. Initials: _____
2. I understand that I may revoke this Authorization at any time by notifying DPTI's Privacy Officer in writing, but if I do, it will not have any effect on any actions DPTI took before they received the revocation. Initials: _____

(Authorize)_____ _____ _____

Signature of Athlete, Athlete's Parent or Legal Guardian | Date | Relationship to Student Athlete

You may refuse to sign this Authorization. We cannot condition treatment on your signing this Authorization.

By signing and initialing the following statements, I do not authorize the release of such information to the persons listed above.

3. I understand that by not signing this Authorization, I have limited the athletic trainers' ability to release specific health information regarding injuries sustained or pre-existing conditions, on a need to know basis, to the persons listed above. Initials: _____
4. I have read and understand the purpose of this form and DO NOT authorize the release of such information to the persons listed above. Initials: _____

(Decline)_____ _____ _____

Signature of Athlete, Athlete's | Date | Relationship to Student Athlete
Parent or Legal Guardian

PRE-PARTICIPATION HISTORY AND PHYSICAL EVALUATION

(Accurate completion helps our trainer to be prepared for treating your son)

PLAYER'S NAME _____

(First Name, MI, Last Name)

MEDICAL HISTORY

Chronic Illness (Diabetes, Asthma, Other) _____

Seasonal or Food Allergies or other known allergies (bee sting or other insects) _____

Current Medications (Please List) _____

Chronic Injuries/ Surgeries/ Fractures etc. _____

Heart Problems/ Seizures/ Blood Pressure or other Medical Problems _____

Family History (Stroke/ Heart Attack/ Heart Disease) _____

Date of Last Tetanus Shot _____

Date of Last Measles Immunization _____

Explain "YES" Answers

1	**Have you ever been Hospitalized?**	**Y**	**N**
	Have you ever had surgery?	**Y**	**N**
2	**Have you ever passed out during or after exercise?**	**Y**	**N**
	Have you ever had chest pains during or after exercise?	**Y**	**N**
	Have you ever been dizzy during or after exercise?	**Y**	**N**
	Do you tier more quickly than your friends during exercise	**Y**	**N**
	Have you ever had high blood pressure?	**Y**	**N**
	Have you ever been told you had a heart murmur?	**Y**	**N**
	Have you ever had racing of your heart or skipped heart beats?	**Y**	**N**
	Has anyone in your family died from heart problems or a sudden death before age 50?	**Y**	**N**
3	**Do you have any skin problems (itching, rashes, acne)?**	**Y**	**N**
4	**Have you ever had a head injury?**	**Y**	**N**
	Have you ever been knocked out or unconscious?	**Y**	**N**
	Have you ever had seizures?	**Y**	**N**
	Have you ever had a stinger, burner, or pinched nerve?	**Y**	**N**
5	**Have you ever had heat or muscle cramps?**	**Y**	**N**
	Have you ever been dizzy or passed out in the heat?	**Y**	**N**
6	**Do you have trouble breathing or cough during or after activity?**	**Y**	**N**
7	**Do you us any special equipment (pads, braces, neck rolls, etc.)?**	**Y**	**N**

8 **Have you had any problems with your eyes or vision?** **Y** **N**
Do you wear glasses or contacts or protective eye wear? **Y** **N**

9 **Have you ever sprained/ strains, dislocated, fractured, broken or had repeated swelling or other injures of any bones or joints?** **Y** **N**

Please Check all that Apply

____ Head	**____ Shoulder**	**____ Thigh**	**____ Neck**	**____ Elbow**
____ Chest	**____ Forearm**	**____ Shin/ Calf**	**____ Back**	**____ Wrist**
____ Ankle	**____ Hip**	**____ Knee**	**____ Hand**	**_____Foot**

10 **Have you had any medical problems (infectious mononucleosis, diabetes, etc.)?** **Y** **N**

11 **Have you had any Medical problems or injuries since your last school/ sports or medical evaluation?** **Y** **N**

Explain "YES" answers:

_____

_____

____

LEZZER LUMBER CONCUSSION PROTOCOL

If a head injury/concussion is suspected during practice or a game, the following protocol will be implement:

1/ Athlete removed from game/practice following signs/symptoms of concussion.

2/ No return to play in current game/practice if concussion is suspected.

3/ Medical Evaluation by an Appropriate Medical Professional

4/ Contact parents/guardians with educational materials and specific instructions (Head Inj. Info Sheets)

a/ Recommend Physician Referral

5/ Stepwise Return to Play. Each stage, unless directed otherwise by evaluating physician, will be decided by the trainer and team doctor

Any recurrence of concussive symptoms during exercise will result in a 4-day rest 1/complete rest & no activity until asymptomatic symptoms return 2/ Light aerobic exercise 3/ sport-specific training. 4/ Non-contact drills, 5/ Full Contact drills, 6/ Game play (must have written clearance by physician)

We Hereby State that, to the best of our knowledge, the answers to the above are correct and accurate.

_____

Signature of Player **Signature of Parent**

_____

Date

_____

DUE DATE: FEBRUARY 23, 2025

CONCUSSION INSTRUCTIONAL SHEET

Drayer PHYSICAL THERAPY INSTITUTE

A concussion is a bump, blow or jolt to the head or body in which the brain moves quickly back and forth inside the skull causing a "mild" traumatic brain injury.

SIGNS & SYMPTOMS

COGNITIVE *(THINKING/REMEMBERING)*: Difficulty concentrating, difficulty remembering, confusion, feeling slowed down, feeling "in a fog"

PHYSICAL: Headache, nausea or vomiting, dizziness, blurred vision, neck pain, fatigue or low energy, sensitivity to light or noise, balance problems

EMOTIONAL: Irritable, sadness, emotional instability, nervous or anxious

SLEEP: Sleeping less or more than usual, drowsiness, trouble falling asleep

WHAT SHOULD I DO?

» Remove the athlete from play immediately and seek medical attention

» Never return to sports or recreational activities on the same day the injury occurred

» Seek guidance from a healthcare professional experienced and trained in the evaluation and management of concussions to guide a step-based return to activities progression including work, school and play.

» Take time to get better - The brain needs time to heal. Limit activities involving physical and cognitive exertion, such as watching TV, video games, working on computer, texting, driving a car and exercise. Such activities can cause the signs and symptoms of a concussion to worsen or prolong the healing process. These activities should be carefully managed and monitored by a health care professional.

» Make sure that a concussion is reported. Repeat concussions in young athletes can result in more traumatic injuries involving increased swelling or permanent damage to the brain.

If the following symptoms worsen or develop, please contact your doctor or the nearest hospital emergency department *immediately*.

» Drowsy and cannot be awakened
» Weakness, numbness or decreased coordination
» Pupils becoming unequal in size
» Increasing confusion, restless
» Worsening headache
» Repeat vomiting or nausea
» Convulsions or seizures
» Slurred speech or inability to speak
» Inability to recognize people or places
» Loss of or fluctuating level of consciousness
» Increasing irritability, agitation, unusual behavior

DO NOT:

» Drink alcohol

» Use prescription or OTC drugs without medical supervision

» Drive a car or operate machinery

» Engage in physical activity that makes symptoms worse *(eg. exercise, weight lifting, sports)*

» Engage in mental activity that makes symptoms worse *(eg. TV, video games, texting)*

IT IS OK TO:

» Use ice packs on head and neck as needed for comfort

» Eat a carbohydrate-rich diet

» Go to sleep

» Rest (no strenuous mental or physical activity)

IF YOU HAVE QUESTIONS OR CONCERNS, PLEASE CONTACT YOUR ATHLETIC TRAINER.

ATHLETIC TRAINER: _____

CONTACT: _____

I acknowledge that ATC reviewed management of signs and symptoms for concussions and received the concussion instructional sheet.

ATHLETE NAME	PRINTED NAME OF PARENT/GUARDIAN	SIGNED NAME OF PARENT/GUARDIAN	DATE

Printed Player Name_____

Spell exactly how you want to be listed in game program

Insurance Information and Medical Treatment Permission

The insurance we purchase for the Lezzer Lumber Football Classic is a secondary to insurance already covering a participant. This means that any other insurance is used first, then our policy begins coverage. The company must be informed how many players are covered by other insurance and how many are not – there is a different fee schedule for each type.

This is why we are asking for the following insurance information.

Name of Insurance Company_____

Group Name _____ Group Number_____

Name of Primary Policy Holder _____

Most of our players are over 18 years old. However, the following permission helps ensure a smoother access to treatment should that be necessary.

We give permission to the Trainers and staff of the Lezzer Lumber Classic to authorize necessary first aid and emergency treatment in the event we cannot be reached in person.

_____	_____	_____
Printed Player Name	Date	Printed Parent/Guardian Name
_____	_____	_____
Player Signature	Date	Parent/Guardian Signature
_____	_____	
Cell Phone Number	Emergency Contact Information	