

**KENOSHA BRADFORD HIGH SCHOOL ("School")  
Sports Medicine Emergency Information and Consent**

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Parent/Guardian 1 Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Parent/Guardian 2 Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Alternate Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**IN CASE OF EMERGENCY, PLEASE NOTIFY:**

First, Try:	<input type="checkbox"/> Parent/Guardian 1	<input type="checkbox"/> Parent/Guardian 2	<input type="checkbox"/> Alternate Emergency Contact
Then, Try:	<input type="checkbox"/> Parent/Guardian 1	<input type="checkbox"/> Parent/Guardian 2	<input type="checkbox"/> Alternate Emergency Contact
Then, Try:	<input type="checkbox"/> Parent/Guardian 1	<input type="checkbox"/> Parent/Guardian 2	<input type="checkbox"/> Alternate Emergency Contact

**STUDENT'S MEDICAL INFORMATION**

Primary Doctor: \_\_\_\_\_ Phone: \_\_\_\_\_  
Current Medications: \_\_\_\_\_  
Known Allergies: \_\_\_\_\_  
Other Medical Conditions: (asthma, diabetes, previous head injuries, etc. Use back of sheet if needed) \_\_\_\_\_

(continued on back)

Name of Medical Insurance Company or Plan: \_\_\_\_\_  
Policy Number: \_\_\_\_\_ Is plan an HMO?  Yes  No  
If plan is an HMO, what is your primary care facility? \_\_\_\_\_

**MEDICAL CONSENT TO TREAT STUDENT; AUTHORIZATION TO DISCLOSE STUDENT'S MEDICAL INFORMATION**

*Consent may be required in order for Student to participate in an athletic program. Consent is effective until it is revoked by a parent or guardian, or until Student is no longer enrolled at the School.*

**If no box is checked, it is assumed that consent is NOT given. Please check all applicable.**

- Yes  No The athletic staff, including athletic trainers, coaches, or other qualified personnel may apply first aid treatment for any injury sustained during participation in athletic programs sanctioned by School.
- Yes  No The athletic trainer may evaluate and treat other emergent or non-emergent Student injuries or medical conditions brought to the athletic trainer's attention as they relate to the Student's physical activity, conditioning or injury prevention.
- Yes  No If the athletic staff determines that Student is in need of immediate medical attention beyond that which can be provided by the athletic staff at School and the Student's parent, guardian, or emergency contact cannot be reached, the athletic staff may use their judgment in securing medical aid, including ambulance service and admittance to a hospital if needed.
- Yes  No If available at School, School's athletic trainer may provide appropriate treatment modalities, such as ultrasound and electronic stimulations to treat any Student injury or other medical condition.

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Parent 1     Parent 2     Guardian (relationship) \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**KENOSHA BRADFORD HIGH SCHOOL  
AUTHORIZATION TO DISCLOSE STUDENT'S MEDICAL INFORMATION**

If this document is not signed, it is assumed that authorization is **NOT** given. Authorization is effective until it is revoked by a parent or guardian, or until Student is no longer enrolled at the School.

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

The purpose of this authorization is to permit disclosure of Student's protected health information (PHI) among health care professionals, coaches, athletic training staff, insurance personnel, and academic counselors and administrators. This disclosure allows athletic medical staff and School to make certain decisions about Student's health and ability to participate in certain athletic programs sanctioned by School in accordance with the Health Information Portability and Accountability Act (HIPAA). HIPAA protects personal injury and illness information from disclosure without authorization under HIPAA. Student's PHI includes, but is not limited to, information involving the nature and treatment of an injury or illness, medical history and status, prognosis, diagnosis, athletic participation status, insurance coverage, and copies of hospital and medical records.

Pursuant to this signed authorization, athletic training staff, including trainers, coaches, or other qualified personnel of Kenosha Bradford High School (School) are authorized to disclose Student's PHI verbally or in writing, as necessary and appropriate for the purpose of health care treatment or exchanging information regarding Student's health as permitted or required under the law (e.g. determining Student's ability and eligibility to participate in athletic programs sanctioned by School, evaluating injuries and other medical conditions which Student reports while engaging in athletic programs sanctioned by School, etc.).

The Student's PHI may be disclosed to:

- (1) School's coaches, athletic director, or other members of School's administrative staff or their designees;
- (2) Student's parents and guardians; and
- (3) Emergency medical personnel, hospitals, or other health care professionals who evaluate, diagnose or treat an injury, illness, or other condition incurred by Student while participating in athletic programs sanctioned by School, as necessary to:
  - (a) Evaluate Student's eligibility to participate in School activities, including but not limited to interscholastic or intramural sports programs and physical education classes;
  - (b) Document and evaluate first aid treatment and athletic treatment modalities provided;
  - (c) Evaluate treatment alternatives; and
  - (d) Resolve disputes that arise with regard to the above.

Signing this authorization/consent is voluntary, and authorization may be revoked at any time by a written revocation sent to both School's athletic department and athletic training staff. However, authorization may be required in order for Student to participate in an athletic program. Any revocation will not apply to information that has already been released. Student and Student's parents and guardians reserve the right to review all records and to obtain a copy of all records released at any time upon request. In the event that Student's PHI is re-disclosed by a person who receives it under this authorization, it will no longer be covered by this authorization.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Parent Name: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_