GEISINGER

SPORTS MEDICINE

ImPACT©

The Best Approach To Concussion Management

May 15 2018

Dear Parent/Guardian,

Geisinger Sports Medicine and your child's high school are well prepared to provide care to your student athlete. Over the last several years there has been a significant increase in awareness and media coverage of concussions and mild head injuries. We feel it is important you know Millville School District and Geisinger are on the forefront of concussion care for your student athlete. We have a highly integrated medical network of professionals ready to address these medical needs.

We continue to evaluate and treat patients with concussions using the latest research and data. We also use a software tool called ImPACT to assist our health care providers. ImPACT is not new and is the industry standard of care. We have utilized ImPACT at Millville the last 9 years. This is a computerized assessment utilized in many professional, collegiate, and high school sports programs across the country to help manage concussions. How is this used? ImPACT can be utilized during an athletic trainer's exam or during a physician's exam to help determine the recovery progress of a head injury and when it is safe for the injured player to return to their sport.

The computerized exam is utilized best when given to athletes prior to beginning contact sport practice or competition. **Essentially, the ImPACT test is a preseason physical of the brain.** This non-invasive test is set up in "video-game" type format and takes about 15-20 minutes to complete. It is simple, and actually many athletes enjoy the challenge of taking the test. It tracks information such as memory, reaction time, speed, and concentration. It, however, is NOT an IQ test. Injury tracking has demonstrated over a number of years that certain sports have a higher incidence of concussions. Considering injury statistics and associated risk within respective sports, Geisinger Sports Medicine and your high school has determined only contact sports will have their athletes baseline tested. These sports include boys' and girls' soccer, field hockey, boys' and girls' basketball and wrestling. Baseline tests are obtained every other year unless a student athlete suffers a concussion, in which case they are baseline tested every year.

When a concussion is suspected, the athlete will be required to re-take the test. The information gathered will be used by our sports medicine physicians and can also be shared with your family doctor. The test data will enable these health professionals to determine when return-to-play is appropriate and safe for the injured athlete. If an injury of this nature occurs to your child, you will be promptly contacted with all the details.

The information gathered from the ImPACT program may also be utilized in future concussion studies. To ensure and guarantee your child's anonymity, ImPACT has set-up an anonymous data submission system.

Why should your son or daughter participate?

Participation is optional. However, it will be a health benefit to your son/daughter in the unfortunate circumstance that they experience or are suspected of having a concussion. This testing is just another tool a physician can use to determine and diagnose the severity of a concussion. This testing DOES NOT take the place of a physician. The results from this test do not necessarily hold an athlete out of participation or give them clearance to play. A clinical evaluation is always needed in addition to utilizing this tool much like an MRI is correlated with a physical exam.

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Where can I find out more information about this test?

Your school Athletic Trainer is an excellent resource. They are trained professionals to recognize the signs and symptoms of a concussion and manage their treatment in conjunction with a physician. The National Athletic Trainers' Association released a position statement for the management of concussions available here:

http://www.nata.org/sites/default/files/MgmtOfSportRelatedConcussion.pdf

http://www.nata.org/NR040907

ImPACT also has an excellent collection of resources at www.impacttest.com.

We wish to stress that the ImPACT testing procedures are non-invasive, and they pose no risks to your student-athlete. We are excited to implement this program given that it provides us the best available information for managing concussions and preventing potential brain damage that can occur with multiple concussions. The School administration, coaching, and athletic training staffs are striving to keep your child's health and safety at the forefront of the student athletic experience. Please return the attached page with the appropriate signatures. If you have any further questions regarding this program please feel free to contact me at 271-6700.

Sincerely,

Cassie M Kremer, LAT, ATC
Geisinger Musculoskeletal Institute
16 Woodbine Lane
Danville, PA 17821
Phone: (570) 271-6700
Fx: (570) 214-6700
Email: cmkremer1@geisinger.edu
Toll Free: 866-414-4988

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Consent Form

For use of the Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT)

I have read the attached information. I understand its contents. I have been given an opportunity to ask questions and all questions have been answered to my satisfaction. I agree to participate in the ImPACT Concussion Management Program.

Printed Name of Athlete _____

Sport _____

_____ _____

Signature of Athlete Date

_____ _____

Signature of Parent/Guardian Date

PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION

INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION

Student's Name _____ Male/Female (circle one)

Date of Student's Birth: ____/____/_____ Age of Student on Last Birthday: ____ Grade for Current School Year: ____

Current Physical Address _____

Current Home Phone # ( )_____ Parent/Guardian Current Cellular Phone # ( )_____

Fall Sport(s): _____ Winter Sport(s): _____ Spring Sport(s): _____

EMERGENCY INFORMATION

Parent's/Guardian's Name_____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Secondary Emergency Contact Person's Name _____ Relationship _____

Address _____ Emergency Contact Telephone # ( )_____

Medical Insurance Carrier_____ Policy Number_____

Address _____Telephone # ( ) _____

Family Physician's Name_____, MD or DO (circle one)

Address _____Telephone # ( ) _____

Student's Allergies_____

Student's Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware_____

_____

_____

_____

Student's Prescription Medications and conditions of which they are being prescribed _____

_____

SECTION 2: CERTIFICATION OF PARENT/GUARDIAN

The student's parent/guardian must complete all parts of this form.

A. I hereby give my consent for _____ born on _____ who turned _____ on his/her last birthday, a student of _____ School and a resident of the _____ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____ - 20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

Fall Sports	Signature of Parent or Guardian
Cross Country	
Field Hockey	
Football	
Golf	
Soccer	
Girls' Tennis	
Girls' Volleyball	
Water Polo	
Other	

Winter Sports	Signature of Parent or Guardian
Basketball	
Bowling	
Competitive Spirit Squad	
Girls' Gymnastics	
Rifle	
Swimming and Diving	
Track & Field (Indoor)	
Wrestling	
Other	

Spring Sports	Signature of Parent or Guardian
Baseball	
Boys' Lacrosse	
Girls' Lacrosse	
Softball	
Boys' Tennis	
Track & Field (Outdoor)	
Boys' Volleyball	
Other	

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at www.piaa.org, include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent's/Guardian's Signature _____ Date____/____/_____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent's/Guardian's Signature _____ Date____/____/_____

D. Permission to use name, likeness, and athletic information: I consent to PIAA's use of the herein named student's name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent's/Guardian's Signature _____ Date____/____/_____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student. I hereby agree to pay for physicians' and/or surgeons' fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school's athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent's/Guardian's Signature _____ Date____/____/_____

F. CONFIDENTIALITY: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school's athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent's/Guardian's Signature _____ Date____/____/_____

SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?
A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student's brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been "dinged" or "had their bell rung."

All concussions are serious. A concussion can affect a student's ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student's brain time to heal.

What are the symptoms of a concussion?
Concussions cannot be seen; however, in a potentially concussed student, ***one or more*** of the symptoms listed below may become apparent and/or that the student "doesn't feel right" soon after, a few days after, or even weeks after the injury.

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?

- **Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents.** Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- **The student should be evaluated.** A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- **Concussed students should give themselves time to get better.** If a student has sustained a concussion, the student's brain needs time to heal. While a concussed student's brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student's brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.

- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  The right equipment for the sport, position, or activity;
  Worn correctly and the correct size and fit; and
  Used every time the student Practices and/or competes.
- Follow the Coach's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don't hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student's Signature _____ Date____/____/_____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent's/Guardian's Signature _____ Date____/____/_____

SECTION 4: UNDERSTANDING OF SUDDEN CARDIAC ARREST SYMPTOMS AND WARNING SIGNS

What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart's electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may *also* hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

_____ _____ Date____/____/_____

Signature of Student-Athlete | Print Student-Athlete's Name

_____ _____ Date____/____/_____

Signature of Parent/Guardian | Print Parent/Guardian's Name

Student's Name _____ Age_____ Grade_____

SECTION 5: HEALTH HISTORY

Explain "Yes" answers at the bottom of this form.
Circle questions you don't know the answers to.

		Yes	No
1.	Has a doctor ever denied or restricted your participation in sport(s) for any reason?	☐	☐
2.	Do you have an ongoing medical condition (like asthma or diabetes)?	☐	☐
3.	Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills?	☐	☐
4.	Do you have allergies to medicines, pollens, foods, or stinging insects?	☐	☐
5.	Have you ever passed out or nearly passed out DURING exercise?	☐	☐
6.	Have you ever passed out or nearly passed out AFTER exercise?	☐	☐
7.	Have you ever had discomfort, pain, or pressure in your chest during exercise?	☐	☐
8.	Does your heart race or skip beats during exercise?	☐	☐
9.	Has a doctor ever told you that you have (check all that apply): ☐ High blood pressure ☐ Heart murmur ☐ High cholesterol ☐ Heart infection		
10.	Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram)	☐	☐
11.	Has anyone in your family died for no apparent reason?	☐	☐
12.	Does anyone in your family have a heart problem?	☐	☐
13.	Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50?	☐	☐
14.	Does anyone in your family have Marfan syndrome?	☐	☐
15.	Have you ever spent the night in a hospital?	☐	☐
16.	Have you ever had surgery?	☐	☐
17.	Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a Practice or Contest? If yes, circle affected area below:	☐	☐
18.	Have you had any broken or fractured bones or dislocated joints? If yes, circle below:	☐	☐
19.	Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:	☐	☐

Head Neck Shoulder Upper arm Elbow Forearm Hand/ Fingers Chest
Upper back Lower back Hip Thigh Knee Calf/shin Ankle Foot/ Toes

20.	Have you ever had a stress fracture?	☐	☐	
21.	Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability?	☐	☐	
22.	Do you regularly use a brace or assistive device?	☐	☐	
23.	Has a doctor ever told you that you have asthma or allergies?	☐	☐	
24.	Do you cough, wheeze, or have difficulty breathing DURING or AFTER exercise?	☐	☐	
25.	Is there anyone in your family who has asthma?	☐	☐	
26.	Have you ever used an inhaler or taken asthma medicine?	☐	☐	
27.	Were you born without or are your missing a kidney, an eye, a testicle, or any other organ?	☐	☐	
28.	Have you had infectious mononucleosis (mono) within the last month?	☐	☐	
29.	Do you have any rashes, pressure sores, or other skin problems?	☐	☐	
30.	Have you ever had a herpes skin infection?	☐	☐	
	CONCUSSION OR TRAUMATIC BRAIN INJURY			
31.	Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury?	☐	☐	
32.	Have you been hit in the head and been confused or lost your memory?	☐	☐	
33.	Do you experience dizziness and/or headaches with exercise?	☐	☐	
34.	Have you ever had a seizure?	☐	☐	
35.	Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?	☐	☐	
36.	Have you ever been unable to move your arms or legs after being hit or falling?	☐	☐	
37.	When exercising in the heat, do you have severe muscle cramps or become ill?	☐	☐	
38.	Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease?	☐	☐	
39.	Have you had any problems with your eyes or vision?	☐	☐	
40.	Do you wear glasses or contact lenses?	☐	☐	
41.	Do you wear protective eyewear, such as goggles or a face shield?	☐	☐	
42.	Are you unhappy with your weight?	☐	☐	
43.	Are you trying to gain or lose weight?	☐	☐	
44.	Has anyone recommended you change your weight or eating habits?	☐	☐	
45.	Do you limit or carefully control what you eat?	☐	☐	
46.	Do you have any concerns that you would like to discuss with a doctor?	☐	☐	
	FEMALES ONLY	☐	☐	
47.	Have you ever had a menstrual period?	☐	☐	
48.	How old were you when you had your first menstrual period?	_____		
49.	How many periods have you had in the last 12 months?	_____		
50.	Are you pregnant?	☐	☐	

#'s	Explain "Yes" answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student's Signature _____ Date____/____/_____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent's/Guardian's Signature _____ Date____/____/_____

SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student's comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal's designee, of the student's school.

Student's Name _____ Age_____ Grade_____

Enrolled in _____ School Sport(s) _____

Height_____ Weight_____ % Body Fat (optional) _____ Brachial Artery BP_____/_____ (_____/_____ , _____/_____) RP_____

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student's primary care physician is recommended.

Age 10-12: BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/_____ L 20/_____ Corrected: YES NO (circle one) Pupils: Equal_____ Unequal_____

MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance		
Eyes/Ears/Nose/Throat		
Hearing		
Lymph Nodes		
Cardiovascular		☐ Heart murmur ☐ Femoral pulses to exclude aortic coarctation ☐ Physical stigmata of Marfan syndrome
Cardiopulmonary		
Lungs		
Abdomen		
Genitourinary (males only)		
Neurological		
Skin		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder/Arm		
Elbow/Forearm		
Wrist/Hand/Fingers		
Hip/Thigh		
Knee		
Leg/Ankle		
Foot/Toes		

I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student's HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student's parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

☐ **CLEARED** ☐ **CLEARED**, with recommendation(s) for further evaluation or treatment for:_____

☐ **NOT CLEARED** for the following types of sports (please check those that apply):

☐ COLLISION ☐ CONTACT ☐ NON-CONTACT ☐ STRENUOUS ☐ MODERATELY STRENUOUS ☐ NON-STRENUOUS

Due to _____

Recommendation(s)/Referral(s) _____

AME's Name (print/type) _____ License #_____

Address_____ Phone ( )_____

AME's Signature_____MD, DO, PAC, CRNP, or SNP *(circle one)* Certification Date of CIPPE ___/___/___

HIPAA FORM FOR STUDENT ATHLETES

All student athletes are being asked to complete and return the following RELEASE form prior to being able to participate in athletics. This form is strongly recommended to ensure that we are in compliance with the Health Insurance Portability and Accountability Act (HIPAA). The HIPAA law was put in place to ensure confidentiality of individuals requiring medical care. Every athlete has their individual rights protected regarding medical records. As Millville School District's Certified Athletic Trainer, I am routinely asked to share pertinent athletic medical information on the athletes between your Physicians, Millville nursing staff, principal and coach. This ONLY PERTAINS TO ATHLETIC INFORMATION. Sharing this information is necessary for the athletic trainer and coach to protect the student athlete when they are playing with an injury or being treated by the athletic trainer for an injury.

By federal law, we must have a signed authorization form permitting me, the Certified Athletic Trainer, to disclose protected health information about the student/athlete to the nurse, principal and coaching staff, . This would include the injury specifics, severity of the injury, and the status for return to play. For example, if your son or daughter experiences a concussion, they may have difficulty within the classroom. Having a signed HIPAA form allows me to communicate with the nurse who will notify your child's teachers that academic arrangements may be necessary due to this injury.

In order for your son/daughter to be able to participate in athletics, I am asking that a copy of this form be on file at the school. This form will only need to be completed one time per year prior to the start of the sports season. These forms will be available in the main office at your school. I appreciate your help in ensuring that this form is completed and turned in prior to your son/daughters sports season.

Sincerely,

Cassie M Kremer, LAT, ATC
Geisinger Musculoskeletal Institute
16 Woodbine Lane
Danville, PA 17821
Phone: (570) 271-6700
Fx: (570) 214-6700
Email: cmkremer1@geisinger.edu
Toll Free: 866-414-4988

AUTHORIZATION TO RELEASE ATHLETIC MEDICAL INFORMATION

Patient Name: _____
Address: _____
Address: _____
Birthdate: _____
Medical Record No.: _____

• GEISINGER EMPLOYEE USE ONLY •

[X] Geisinger Medical Center
100 N. Academy Avenue
Danville, PA 17822

[X] Geisinger Wyoming Valley Medical Center
1000 E. Mountain Boulevard
Wilkes-Barre, PA 18711

[X] Geisinger Clinic (GMG)
_____
_____
(Specify site and address)

(AS APPLICABLE)

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to: Officials of the school that I (Student Athlete) attend. This would include, the coaching staff, athletic directors, insurance carriers and health-care professionals who are involved with my participation in **interscholastic athletics.**

_____
(Address and Phone number of receiving party)

for the purpose of: X continuation of medical treatment X payment of bill ☐ Worker's Compensation X education X legal purposes X insurance purposes X at the request of the patient or the patient's legal representative for personal access or other (specify): _____

The information to be released will cover the time period from _____06/01/18_____ to ____06/01/19_____

SPECIFIC INFORMATION TO RELEASE:

-All information concerning my health that impacts my ability to participate in interscholastic athletics.
This may include information about injuries (such as sprains), surgeries, or medical conditions (such as concussions, asthma etc.). This is to inform the above referenced people of my health –related limitations and abilities to continue to participate in **interscholastic athletics**.

–To provide the above referenced people with information on how to help me safely participate in interscholastic athletics

I understand that in order to process this request for the reproduction of medical record information on a timely basis, the above entity(ies) may utilize a contracted medical record copy service, and I further authorize the release of my medical record information to such record service for this purpose. I understand that this authorization is revocable by me, in writing, at any time, except to the extent that action has been taken in reliance on it. I will contact the above entity(ies) immediately if I wish to revoke this authorization. As described in the Notice of Privacy Practices for the above entity(ies), I may request such Notice of Privacy Practices for my ease of reference. I understand that the information released may be re-released by the recipient and may no longer be protected by HIPAA (Federal regulations). The above entity(ies) may not condition my treatment or payment for my treatment on obtaining this authorization from me, unless this authorization is requested (i) to provide research-related treatment to me, or (ii) because the health care being provided to me is solely for the purpose of creating protected health information for disclosure to a third party.

SPECIAL AUTHORIZATION (if applicable)

If you are authorizing the above entity(ies) to release information related to the testing, diagnosis and/or treatment for any of the following conditions, please sign your initials in front of the section which describes the type of information to be released.

_____ Parent/guardian _____ Patient/athlete — My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to the recipient noted above.

_____ Parent/guardian _____ Patient/athlete — My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological information may be released to the recipient noted above.

_____ Parent/guardian _____ Patient/athlete — My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted above.

AUTHORIZATION SIGNATURES

Date: _____ **Patient/Athlete Signature:** _____

Date: _____ **Witness Signature:** _____

Date: _____ **Parent/Guardian Signature:** _____

Date: _____ **Witness Signature:** _____

**********COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT**********

Copy: Medical Record *Copy: Patient*