Sports Medicine Program Consent for Medical Care and Treatment

I, _____, the parent/legal guardian of _____, a student at _____(the "School") whose date of birth is_____, authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., The McDowell Hospital, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") and associated staff to provide my child such healthcare or other services offered by the Sports Medicine Program and, where appropriate, to make referrals for my child to receive additional health services that my child's condition may indicate. *In any such event, student athletes and their parents/legal guardians shall have the option to choose any medical provider as they and/or their legal guardian(s) may choose, as many options are available to student athletes. No student and/or his or her parents/guardians are required to utilize Mission for medical services.*

Pre-Participation Physical. I hereby give my consent/permission to Mission and participating, licensed or other medical providers to perform a pre-participation screening physical examination ('screening exam") for my child. I agree that this screening exam is only a limited, screening examination and does not take the place of a complete medical examination. I understand and agree that the medical provider(s) completing the screening exam shall not be responsible for any ongoing medical care or treatment for any medical condition or for injuries that occur after the screening exam. I represent, to the best of my knowledge, that my child has no known medical condition that would prevent participation in sports. I agree to follow up with my child's primary care provider in the event that any medical condition is identified in the screening exam.

Injury and/or Emergency Treatment: In the event that it becomes necessary, I agree that the team physician or athletic trainer, as appropriate, may provide medical care and/or treatment to my child as provided herein for a sports-related injury. In addition, in the event my child needs urgent or emergency treatment, I authorize the staff of the School and/or Mission, where appropriate, to arrange for such care with appropriate providers, including appropriate transportation. In such instance, I authorize the School and/or Mission, where appropriate, to undertake any acts which may be necessary or proper to provide for the health care of the minor child named herein, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any health care, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures. By signing below, I indicate that I have the understanding and capacity to communicate health care decisions on behalf of the child named herein and that I understand the contents of this document. I understand that the School staff and/or the Mission staff, as appropriate, will contact me as soon as possible in the event my child has an urgent or emergency condition.

Payment for Services Rendered. I understand that I will not be charged by Mission for services rendered on-site by the Mission Athletic Trainer or other Mission Sports Medicine staff assigned to the school but that I or my insurance carrier may be charged for services rendered by other healthcare providers for follow-up care or treatment.

Health Information. I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the School's athletic events and as required for medical care and treatment or other services provided by Mission. I understand that I may contact the Mission Athletic Trainer or the Team Physician assigned to the School or the Mission Medical Director to discuss my child's care or to discuss any questions that I may have about the program.

Neurocognitive Testing. I understand and agree that my child may undergo a computerized concussion evaluation system, such as ImPACT, as part of an overall concussion management protocol. https://www.impacttest.com/about

Students. I understand and agree that Mission is involved in the education of student athletic trainers (at the college level and student aides at the high school level), physicians, nurses, technicians and other health care providers, interns, and observers. I understand and agree that these individuals may participate as is appropriate in providing athletic training, medical care and/or treatment to my child as provided herein for a sports-related injury or otherwise.

Medication. Athletic Trainers are not responsible for an athlete's prescription or non- prescription medication(s). An athletic trainer may, under the supervision and protocol of a provider, receive, store, and administer medication to my child and/or store my child's medication for the duration of an athletic event upon my request.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE AND CONSENT TO MY CHILD'S PARTICIPATION IN THE MISSION SPORTS MEDICINE PROGRAM AND TO THE OTHER TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

_____ _____

Name of Parent/Legal Guardian (Please Print) Name of Student (Please Print)

_____ _____

Signature of Parent/Legal Guardian Relationship to Student

Date of Signature:_____

AUTHORIZATION FOR ACCESS, USE, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____, the parent/legal guardian of_____, a student at _ (the "School") whose date of birth is_____, authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., The McDowell Hospital, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") consent to and authorize the release by Mission of information about my child's medical condition obtained through the Sports Medicine Program to the School's named coaches and other employees or agents of the School. I also specifically consent to and authorize the sharing of my child's medical information among the Mission Sports Medicine staff (team physicians, if any, other medical staff/providers, athletic trainers, and any student assistants) and the School's athletic staff, teachers/coaches, and school administration.

My signature below indicates that I understand and agree to the following:

1. This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
2. As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
3. My decision to sign this authorization will not have an effect on the treatment provided to my child by any applicable health care provider, the cost of that treatment, or any benefits.
4. I may revoke this authorization at any time by notifying Mission in writing.
5. Revoking this authorization will not affect any disclosures made prior to revoking this authorization.
6. Unless revoked or an **expiration date** is indicated here_____, this authorization will extend until the end of the athletic season for which my child is engaged (2017-2018 athletic year).
7. After release my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permission.
8. Mission will not use or share my health information without my permission, except as allowed or required by law.
9. This form will not be used for marketing or research.
10. A fee may be charged for providing any requested medical records.
11. I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my child's health information as described in this form.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THE TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.

_____ Name of Parent/Legal Guardian (Please Print)

_____ Name of Student (Please Print)

_____ Signature of Parent/Legal Guardian

_____ Relationship to Student

Date of Signature:_____

Medication Agent Form

This form must be completed if you authorize the Athletic Trainer to administer prescribed medications to your child as needed for conditions such as allergies (epi pen), diabetes (insulin), or asthma (inhaler).

I,_____, the parent/legal guardian of

_____, a student at _____

(the "School") whose date of birth is _ , authorize Mission Health System, Inc. and each of its affiliated, participating hospitals as applicable including Mission Hospital, Inc., Blue Ridge Regional Hospital, Inc., The McDowell Hospital, Inc., Angel Medical Center, Inc., Highlands-Cashiers Hospital, Inc. and Transylvania Community Hospital, Inc. (collectively and/or individually as is applicable referred to herein as "Mission") and their respective staff , as applicable, under the supervision and protocol of a physician, to receive, store, and administer indicated medication, which is prescribed in my child's name.

The medication is:_____

I authorize the release of any information pertaining to my listed medications to Mission.

Printed Athlete's Name: _ DOB: _____

Medication(s) Prescribed: _____

Prescribing Physician Name, Address, and Phone Number:

_____

Condition requiring Prescription: _____

Dosage and Administration Instructions:

_____

_____

_____ _____

Name of Parent/Legal Guardian (please print) Relationship to Student

_____

Signature of Parent/Legal Guardian Date