Bon Secours St. Francis Health System, Inc.
St. Francis Sports Medicine

Name _____ DOB _____

SSN _____ Phone # _____ Cell # _____

Grade _____ Sport(s) _____

Address _____

Mother _____ Work # _____

Home # _____ E-mail _____

Father _____ Work # _____

Home # _____ E-mail _____

Insurance Carrier _____

Emergency Contact _____

Phone #'s _____

Yes/ No Does your child have any of the following? (check appropriate box and list details)

- ☐ ☐ Medical Alert Allergies _____
- ☐ ☐ Allergic to any medication(s) _____
- ☐ ☐ Asthma _____ Do you have an Inhaler? _____
- ☐ ☐ Heart Condition _____
- ☐ ☐ Vision loss _____
- ☐ ☐ Epilepsy _____
- ☐ ☐ Diabetes _____
- ☐ ☐ Kidney condition _____
- ☐ ☐ Hearing loss _____
- ☐ ☐ Severe headaches _____
- ☐ Other _____

Additional medical information:

Previous injuries/surgeries (month/year)? _____

Date of last tetanus booster: _____

Is your child on any medication that is taken on a regular basis? (List) _____

Does your family have a primary care physician? (Name/ phone#)

Does your family have an orthopedic MD? _____

My child may take any over-the-counter medication such as Tylenol®/Advil® ☐ yes ☐ no

Specific _____

Parent/Guardian Signature _____ Date _____

BON SECOURS ST. FRANCIS HEALTH SYSTEM, INC.
CERTIFIED ATHLETIC TRAINING SERVICES
CONSENT AND AUTHORIZATION

I, _____, parent/legal guardian of _____, a student at _____ (the "School"), authorize Bon Secours St. Francis Health System, Inc., SFHS staff to provide my child any healthcare services offered by SFHS Certified Athletic Training Services 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 student athletes, SFHS will provide an athletic trainer to provide on-site treatment and consultation to students at the School. These services will be overseen by a physician serving as Medical Director for Certified Athletic Training Services.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff at SFHS Certified Athletic Training Services to arrange for such care, including appropriate transportation. I understand that SFHS Certified Athletic Training Services 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 Certified Athletic Training Services program. I understand that I may contact the trainer assigned to the School or the Medical Director for Certified Athletic Training Services to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by SFHS staff of information about my child's medical condition obtained through Certified Athletic Training Services to coaches and other employees or agents of the School.

I understand that I will not be charged for services rendered on-site by the trainer assigned to the School, but that I or my insurance carrier will 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 SFHS to submit claims for services rendered to my child and assign to SFHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by SFHS Certified Athletic Training Services, I hereby release Bon Secours St. Francis Health System, its trustees, officers, employees, and agents from and against any claim, liability, cause of action or other expense arising out of the services provided by SFHS Certified Athletic Training Services.

I have read and understand the above information and consent to my child's participation in SFHS Certified Athletic Training Services.

_____
Name of Parent (of minor patient), Closest Relative, or Other Legal Representative (please print)

_____
Name of Student (please print)

_____
Signature of Parent (of minor patient), Closest Relative, or Other Legal Representative

_____
Relationship to Student (please print)

_____
Witness

_____
Date

Emergency Contact Names

Telephone Numbers

_____ Day _____ Night _____

_____ Day _____ Night _____