PARENT CONSENT FOR EXAMINATION AND TREATMENT

(This must be completed yearly in order for your child to participate in sports for Swain County)

ATHLETE NAME_____ AGE_____ GRADE_____

SCHOOL_____

Parent/Guardian Name_____

Home Address_____

Home Phone (____)_____ Cell Phone (____)_____

Work Phone (____)_____ Other Phone (____)_____

Insurance Information_____ Policy #_____

Emergency Contact Person_____ Phone (____)_____

Family Physician _____ Phone (____)_____

PRE-SCREENING PHYSICAL (if my child when through the "free sports physical" for Swain County): I hereby give my informed consent for the participating physician(s) to perform a pre-participation screen physical examination on my child. I realize that this is only a screening examination and does not take the place of a complete examination. During a screening, the physician is not responsible for any ongoing medical care or treatment of any injuries that occur on the day of the examination or subsequently. My child has no known serious medical conditions that would prevent him/her from participating in sports that I am aware of. I agree to follow up with my local physician if anything preventing participation is found by the screening.

EMERGENCY TREATMENT: In the event of a medical emergency, every attempt to notify the parent or guardian will be made. However, if you cannot be reached, we ask that you grant permission for your child to be treated for a medical emergency by a licensed physician, certified athletic trainer or any other person trained in emergency care. In the event that I cannot be reached, I grant permission to the SWAIN COUNTY SCHOOLS / CAROLINA WEST/MEDWEST SPORTS MEDICINE to provide emergency medical treatment to my son or daughter (named above) by a licensed medical physician.

PRACTICE / GAME INJURY CLINIC TREATMENT CONSENT: Local, licensed physicians will be serving as our team physicians when possible. We ask that you sign and give permission to these physicians to treat your son or daughter for any sports related injury. I understand that no surgical procedures will be performed without my further consent.

ATHLETIC TRAINING SERVICES CONSENT: Nationally certified and stated licensed athletic trainers will be providing prevention and care of athletic injuries to the Swain County Schools student athletes. The prevention of athletic injuries may include the taping, wrapping, padding or bracing of involved / injured areas. The treatment and care of athletic injuries may include, but not limited to (if available) the use of therapeutic modalities. Some possible modalities available for use by the athletic trainers may include (if available to the athletic trainer): Kinesio taping, ice, moist heat pack, therapeutic ultrasound, cold laser therapy, and electrical stimulation, etc... In the event of a possible concussion the athletic trainer will need to do extensive testing which could include, but not limited to ImPACT, SCAT2, BESS, etc... By signing below you give permission to the certified athletic trainer to provide athletic training services to provide care, use modalities if available (listed above), and treatment for any sports related injury.

ATHLETIC TRAINING CONSENT: During an injury the certified athletic trainer will do everything they can to quickly inform you of any sports related injury and the care that will be needed. However, the environment in which the athletic trainer works in is one that is very different then the controlled environment of a hospital or clinic/office, so if your child gets injured during a game or practice and you (as the parent/guardian) want to know about your child's injury you need to be aware that there are often other people that are around in the area that can overhear what the athletic trainer is saying. If you want a more controlled setting for the athletic trainer to talk with you without other people around to hear the medical information regarding your child's injury (as the parent/guardian) you will need to make this request known to the athletic trainer prior to the athletic trainer informing you of the injury. If you allow the athletic trainer to inform you regarding your child's injury in an uncontrolled environment, with other people around that could overhear the conversation – if you allow this then you are releasing the athletic trainer from ALL HIPAA (Health Insurance Portability and Accountability Act) accounts and cannot hold the athletic trainer accountable for other people overhearing medical information regarding your child's injury.

Also because the athletic trainer works diligently with your child's coach(es) and in order to provide the best care for your child, the athletic trainer will need to inform your child's coach(es) of certain information; in order for your child's coach and the athletic trainer to know how to best work with your child's sport and injury. The athletic trainer will keep your child's information told to a coach(es) to the most minimum amount possible; however, information that could be told to a coach(es) could include, but not limited to: they area of injury, the type of injury, the extent of injury, if there is/was possible surgery involve, if there is/was physical therapy involvement, when your child has/had an appointment with a doctor, dates for scheduled test(s)/exams(s) (ie: MRI/CT/ect…) the possible length of time your child could be out or limited for practice(s) and/or games/ and/or over if the injury could affect your child's next sports seasons. The overall extent of the injury, etc… is the type of information that may need to be made known to your child's coach(es). By signing below you are aware this type of information will need to be shared with your child's coach(es) and you are releasing the athletic trainer from HIPAA (Health Insurance Portability and Accountability Act) accounts by giving your permission for the athletic trainer to share the needed information to your child's coach(es).

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I have fully read and consent to all the above. I fully understand and agree with the information above. By signing below I am giving my full permission to the information above and release Swain's ATHLETIC TRAINER / COUNTY SCHOOLS / CAROLINA WEST/MEDWEST SPORTS MEDICINE.

_____ _____

Parent / Guardian Signature Date

_____

Parent / Guardian PRINT name