Sports Medicine Department
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PATIENT INFORMATION

Last:	First:	Middle Initial:	Date of Birth: / /	Age:
What is your gender identity? ☐ M ☐ F ☐ Other	What sex were you assigned at birth? ☐ M ☐ F		What pronoun do you prefer? ☐ He ☐ She ☐ Other: ________	
Sport:	Year in School:		Student ID#:	
Social Security No.:	Email:		Cell Phone:	
Address:	City:		State:	Zip Code:

INSURANCE INFORMATION

Do you have primary insurance? Yes ☐ No ☐ **If yes, fill out information and attach picture of front and back of insurance card.**

Subscriber Name:	Date of Birth: / /	Phone No.:
Address:		
Insurance Company:	Co. Payment for Office/Specialist:	
Subscriber ID:	Group #:	Policy #:
Claims/Billing Phone No.:	Patient Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	
Insurance Company/Claims Address:		

EMERGENCY MEDICAL TREATMENT OF PARTICIPANT

In the event of a medical emergency, I do ☐ / do not ☐ (please check one) authorize the consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care that the AWC Sports Medicine Staff deem necessary.

IN CASE OF EMERGENCY

Name:	Relationship to Patient:	Phone No.:

I hereby acknowledge that I have no pre-existing injuries/illnesses and am in good physical health to participate in an open event put on by Arizona Western College. If these conditions exist, I have written doctor's clearance to participate in sport or physical activity without restriction. I understand that I am solely responsible for informing the coach or athletic trainers of any medical conditions that I do have. I am also responsible for providing a proper inhaler or emergency medications if applicable. If an emergency contact cannot be reached I authorize Arizona Western College staff to seek/provide emergency medical attention. I will not hold Arizona Western College responsible if any injuries, illnesses, or sudden death is to occur during sport or physical activity. I understand that I will be responsible for any and all costs related to medical treatment provided. Arizona Western College will not be held financially responsible for any athletic or non-athletic injuries during the time of my tryout period.

______________________________ ______________
Student-Athlete Signature Date

______________________________ ______________
Parent/Guardian Signature (If Under 18) Date

ASSUMPTION OF RISK AND LIABILITY WAIVER

I am aware that playing or practicing in any sport can be a dangerous activity involving many risks or injuries. I understand that the risks of participating in sports includes, but are not limited to: death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the musculoskeletal system, and serious injury/impairment to other aspects of my body, general health, and well-being.

Participating in sports can also result in concussion or mild traumatic brain injury. Concussion related symptoms include, but are not limited to, difficulty in thinking or concentrating, loss of consciousness or memory, balance or coordination deficits, dizziness, headache, nausea, confusion, and sleep disturbances. If I do experience any symptomology of a concussion, I affirm that I will immediately stop and report them to my coach or athletic trainer, no matter how minor it appears at the time. I further affirm that I will not participate in any athletic activity until all symptoms have subsided and I have completed the return to play protocol.

Due to the aforementioned dangers of participating in sports, I recognize the importance of following all instruction (from coaching or Sports Medicine Staff) regarding playing techniques, training, rules of the sport, other team rules and to obey such instructions.

In consideration of Arizona Western College permitting me to tryout, practice, or play for an intercollegiate team, and to engage in all activities related therein, including practicing, playing, and travel, I hereby voluntarily assume all risks associated with participation and agree to exonerate and hold harmless Arizona Western College, their officers, agents and employees, the physicians and other practitioners of the healing arts treating me, from any and all liability, claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my voluntary participation. The terms hereof shall serve as a release and assumption of all risks for my heirs, estate, executor, administrator, assignees, and all members of my family.

The undersigned, herewith,

(A) Understands and accepts the risks and dangers of voluntarily participating in intercollegiate athletics,

(B) Understands common concussion symptoms and the responsibility to report any symptomology immediately,

(C) Understands the importance of and accepts to obey all instructions from coaches and sports medicine staff,

(D) Attests that this document serves as an assumption of risk for heirs, family members, etc.

(E) Understands that she/he must refrain from practice or play during medical treatment until she/he is discharged from treatment, or given permission by the clinical practitioner to resume participation despite continuing treatment,

(F) Understands that having passed the physical examination does not necessarily mean that she/he is physically qualified to engage in athletics, only that the examiner did not find a medical reason to disqualify her/him at the time of examination.

____
Student-Athlete Name (Printed)

____ ____________________
Student-Athlete Signature Date

____ ____________________
Parent/Legal Guardgian Signature (If Under 18) Date

NOTICE OF PRIVACY PRACTICES

We understand that information about you and your health is confidential. We are committed to protecting the privacy of this information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice property. We are required, by law, to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.

This notice will tell you about some of the ways in which we may use and disclose health information about you, as well as certain obligations we have regarding the use and disclosure of health information. It will also describe your rights regarding your health information.

How We May Use and Disclose Health Information About You: The medical practice collects health information about you and stores it in a chart and on a computer - this is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The following categories describe some of the different ways that we use your health information within our medical practice and disclose your health information to persons and entities outside our medical practice. We have not listed every use or disclosure within the categories below. In addition, there are some uses and disclosures that will require your specific authorization.

- **Treatment**: We use information about you to provide medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other health care providers who will provide services that we do not. Or we may disclose medical information to others who can help you when you are sick or injured.
- **Payment**: We may disclose medical information to other health care providers to assist them in obtaining payment for services they have provided to you.
- **Health Care Operations**: We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information in our quality assurance activities, to review and improve the quality of care we provide. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also share your information with other healthcare providers that have a relationship with you when they request this information to help them with their quality assessment and improvement activities.
- **Appointment Reminders:** We may use and disclose medical information to contact you and remind you about appointments. If you are unavailable, we may leave this information in a voicemail or in a message with the person answering the phone.
- **Sign-in Sheet**: We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name during treatments.
- **Notification and Communication With Family**: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care. This can include information about your location, your general condition, or, in the event of your death, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communication with your family and others.

Special Situations That Do Not Require Your Authorization: State or federal law permits the following disclosures of your health information without verbal or written permission from you. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law.

- **Military and Veterans**: If you are a member of the Armed Forces, we may release health information about you as required by military command authorities.
- **Workers' Compensation**: We may disclose your health information as needed to comply with workers' compensation laws.
- **Averting A Threat to Health or Safety**: We may use and disclose health information about you, when deemed necessary, to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

•**Health Oversight Activities:** We may disclose health information to a health oversight agency for activities authorized by law – including audits, investigations, inspections, and licensure.
•**Public Health**: We may disclose information about you to public health authorities for purposes related to: preventing or controlling disease injury or disability; reporting child, elder or dependent adult abuse or neglect, reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease of infection exposure
•Lawsuits and Disputes: If you are involved in a lawsuit or dispute, we may be required to disclose health information about you in the course of the administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected.
•**Coroners, Medical Examiners and Mortuaries**: We may disclose health information to a coroner or medical examiner necessary to identify a deceased person or determine the cause of death of a person or aid in their investigation of a death.

When This Medical Practice May Not Use or Disclose Your Health Information:

•Right to Request Special Privacy Protections: You have the right to request restrictions on certain uses and disclosures of your health insurance by written request specifying what information you want to limit and what limitations you wish to have imposed. We reserve the right to accept or reject your request and will notify you of our decision.
•**Right to Request Confidential Communications:** You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular email account or address. We will comply with all reasonable requests submitted in writing.
•**Right to Inspect and Copy:** You have the right to inspect and copy your health information. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it.
•**Right to Amend or Supplement**: You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend it in writing and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information.
•Right to Revocation: You have the right to revoke your authorization for the use or disclosure of your health information except to the extent that action has already been taken. This revocation may be done at any time, by notifying the Sports Medicine Staff in writing.

Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff, and other health care personnel representing Arizona Western College to release information regarding my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics. This protected health information may concern my medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers including hospitals, medical clinics, laboratories, sport specific athletic coaches, strength and conditioning coaches, medical insurance coordinators, parents and/or guardians (unless noted otherwise), insurance carriers, medical supply vendors, and/or medical service companies, sport-specific administrators, and academic counselors. I understand that this information may be disclosed for treatment needs, payment of treatment, improvement of health care operations, health and safety, supports of academic progress and participation status.

____
Name of Student-Athlete (Printed)

____ ________________
Signature of Student-Athlete Date

____ ________________
Signature of Parent/Guardian (If under 18 years of age) Date

CONCUSSION POLICY AND PROTOCOL

INFORMATION

As described in the NCAA Sports Medicine Handbook, a concussion is a “complex physiological process affecting the brain induced by traumatic biomechanical forces”. A concussion is a disturbance in brain function that occurs following either a blow to or a violent shaking of the head, which results in a wide range of physical, cognitive, emotional, and/or sleep related symptoms. It may take days and weeks for concussion symptoms to resolve. Second Impact Syndrome occurs when an athlete sustains a second head injury prior to complete resolution of symptoms from the first injury. Second Impact Syndrome can lead to permanent brain damage or, in extreme cases, death.

Common signs (observed by athletic trainers, coaches, family, friends, etc.): Appears to be dazed, confused about assignment/task, unable to remember plays/score/opponent, slow to respond, clumsy, loss of consciousness, vomiting, behavior or personality changes, inability to focus in conversation, etc. Common symptoms (felt by student-athlete): Headache, nausea, pressure in head, dizziness or balance problems, double/blurry vision, sensitivity to light/noise, feeling sluggish, difficulty concentrating/remembering, confusion, body fatigue, low energy levels, irrational or heightened emotional state, drowsiness, etc.

COLLEGE POLICY

The Sports Medicine Staff utilizes SCAT5 and ImPACT Testing as part of their concussion protocol. These are standardized tools used for evaluating concussions and are helpful in interpreting brain function following an injury. ImPACT is a neurocognitive test done on the computer. All athletes, prior to participation in any intercollegiate sports, are required to take this exam in order to provide a baseline measure in the event of an injury. Athletes are expected to report any concussive symptomology immediately after an injury. Any medical clearance made by a physician will still undergo a guided return to play protocol with the athletic trainer.The athletic trainer is the medical professional representative for Arizona Western College and will make the final decision on return status.

COLLEGE PROTOCOL

All athletes suspected of a concussion will follow this treatment protocol **without exception**.

1. Removal from activity following signs and symptoms of concussion, medical evaluation following injury
2. Return-to-Play Protocol
    a. Phase 1: Rest (no activity) until asymptomatic for 24 hours (including post-concussion symptoms)
    b. Neurocognitive re-test (must “pass” or return to baseline scores prior to moving on in protocol)
    c. Phase 2: Light aerobic exercise
    d. Phase 3: Exertional testing (sport-specific)
    e. Phase 4: Non-contact drills or no “live” practice
    f. Phase 5: Full-contact drills or “live” practice
    g. Phase 6: Unrestricted participation
    If symptoms return at any point during the protocol (including Phase 6), athlete will return to previous phase.
3. Stepwise Return-to-Class Guideline
    a. Case by case, progressive return to classroom setting

I recognize that concussive injuries do have inherent risks that could result in permanent brain damage or death. I certify that I have read and understand the Arizona Western College Athletic Training Concussion Policy and Protocol.

____

Name of Student-Athlete (Printed)

____ ________________

Signature of Student-Athlete Date

____ ________________

Signature of Parent/Guardian (If under 18 years of age) Date

SICKLE CELL TRAIT TESTING WAIVER

INTRODUCTION

Sickle Cell Trait, a common condition, is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. This is a life-long condition that will not change over time. Red blood cells containing the sickle hemoglobin can change shape from round to quarter-moon, or “sickle.” Sickled red cells may accumulate in the bloodstream during intense exercise, blocking normal blood flow to the tissues and muscles. During intense exercise, athletes with sickle cell trait have experienced significant physical distress, collapsed and even died. Heat, dehydration, altitude and asthma can increase the risk for and worsen complications associated with sickle cell trait. Athletes with sickle cell trait are rarely restricted from participation, but athletic trainers and coaches can put precautions in place to protect athletes with the trait. Although Sickle Cell Trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South/Central American ancestry, person of all races and ancestry may test positive for sickle cell trait. For educational materials about SST, go to the following NCAA website: http://www.ncaa.org/health-and-safety/medical-conditions/sickle-cell-trait

COLLEGE POLICY

Arizona Western College requires that student-athletes, prior to participation in any college-sponsored sport activity (including weight training, conditioning workouts, team practices, scrimmages, or contests) be required to undergo a medical examination or evaluation administered by a physician. The examination must now include a sickle cell trait solubility test unless documented results of prior testing are provided to the institution or the student-athlete declines the test and signs a written release. Please note that many newborns in the United States are tested for sickle cell trait at birth, so test result information may already be available within your current medical record.

WAIVER

I, ____ (Print Name), understand and acknowledge that Arizona Western College mandates that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts about sickle trait and sickle cell trait testing.

Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclose of any symptoms, complaints, prior injuries, ailments, and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to Arizona Western College Sports Medicine Staff.

I do not wish to undergo sickle cell trait testing as part of my pre-participation physical examination. I voluntarily agree to release, discharge, indemnify, and hold harmless Arizona Western College, its officers, agents, and employees, the physicians and other practitioners of the healing arts treating me from any and all costs, liabilities, expenses, claims, demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the mandate of Arizona Western College Sports Athletics Department.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age (or have parental/legal guardian’s permission) and competent to sign this waiver.

____ ____________________

Signature of Student-Athlete Date

____ ____________________

Signature of Parent/Guardian (If under 18 years of age) Date