

STEADMAN HAWKINS SPORTS MEDICINE SERVICES  
CONSENT AND AUTHORIZATION

I, \_\_\_\_\_, parent/legal guardian of \_\_\_\_\_, a student/participant at \_\_\_\_\_ (the "School/Event") authorize Greenville Hospital System ("GHS") staff to provide my child any healthcare services offered by Steadman Hawkins Sports Medicine ("SHSM") 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 athletes, GHS will provide athletic trainers to provide on-site treatment and consultation to student/participants. These services will be overseen by a physician serving as Medical Director for SHSM.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff of SHSM to arrange for such care, including appropriate transportation. I understand that SHSM 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 SHSM program. I understand that I may contact the Athletic Trainer assigned to the School or the Medical Director for SHSM to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by GHS/SHSM staff of information about my child's medical condition obtained through SHSM Services to physicians, coaches, and other employees or agents of GHS or to whom I am referred. I also consent to the release of information about my child's medical condition to necessary staff at the school, should accommodations be needed to aid in my child's education.

I understand that I will not be charged for services rendered on-site by the medical staff, but that I or my child's insurance carrier may 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 GHS to submit claims for services rendered to my child and assign to GHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by SHSM, I hereby release Greenville Hospital System, its trustees, officers, employees, and agents from and against any claim, liability, and cause of action or other expense arising out of the services provided by GHS Sports Medicine Services.

I acknowledge by signing below that I have received a copy of the GHS Notice of Privacy Practices.

I have read and understand the above information and consent to my child's participation in GHS Sports Medicine Services.

\_\_\_\_\_  
Name of Parent/Guardian (please print)

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Name of Student (First, Middle, Last)

\_\_\_\_\_  
Witness/Date

STEADMAN HAWKINS SPORTS MEDICINE

Athlete's Name \_\_\_\_\_ DOB \_\_\_\_\_ Grade \_\_\_\_\_  
(First / Middle / Last)

School \_\_\_\_\_ Sport(s) \_\_\_\_\_

Guardian(s) \_\_\_\_\_ Phone #'s (h) \_\_\_\_\_ (c) \_\_\_\_\_  
Relationship(s) \_\_\_\_\_

Address \_\_\_\_\_  
Street City State Zip

Guardian(s) Email \_\_\_\_\_ Student Athlete's Email \_\_\_\_\_  
(For SHSM Emails of Athletic Training/Conditioning Topics)

Emergency contact \_\_\_\_\_ Phone #'s (h) \_\_\_\_\_ (c) \_\_\_\_\_  
(Guardians will be contacted first in case of emergency, please list individual other than listed above)

Ins. Carrier \_\_\_\_\_ HMO/PPO Group/Policy# \_\_\_\_\_  
(circle one)

Insurance Preferred Network/Provider: **yes/no** (circle one) Whom \_\_\_\_\_

Does your child have any of the following? (List details as appropriate)	Yes	No
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Inhaler _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition _____	<input type="checkbox"/>	<input type="checkbox"/>
Vision loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney condition _____	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies _____	<input type="checkbox"/>	<input type="checkbox"/>
Medication Allergy _____	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>

Previous injuries/surgeries (month/year) \_\_\_\_\_  
\_\_\_\_\_

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 orthopaedic doctor? (Name & phone #) \_\_\_\_\_

My child may take any over-the-counter medication such as Tylenol®/Advil® YES NO

\_\_\_\_\_  
Parent/Guardian Signature Date