LAKE-LEHMAN JUNIOR- SENIOR HIGH SCHOOL
HEALTH SERVICES
P.O. Box 38  Lehman, PA  18627-0038

Karen Muldoon, R.N., B.S.N., M.S., Certified School Nurse     Phone: (570) 255-2801

Sport Physical Examination Process

In accordance with the Purpose and Spirit of the PIAA by-laws, Article V and the Lake-Lehman School District, all student athletes are required to have a physical examination in order to participate in athletics for the Lake-Lehman School District.

All attached forms must be completed and returned to the School Nurse or Athletic Trainer. This is the only form that will be accepted in order to participate in athletics at Lake-Lehman School District.

If the PIAA Pre-Participation Physical Evaluation is to be completed at Lake-Lehman Junior–Senior High School by the School Physician, please sign below.

I give my consent for the School Physician (MD, DO, PAC, or CRNP) to examine __________________________________________________________

Student’s Name

Parent’s/Guardian’s Signature:

________________________________________

Date: ______________________
INITIAL EVALUATION: Prior to any student participating in Practices, Inter-School Practices, Scrimmages, and/or Contests, at any PIAA member school in any school year, the student is required to (1) complete a Comprehensive Initial Pre-Participation Physical Evaluation (CIPPE); and (2) have the appropriate person(s) complete the first six Sections of the CIPPE Form. Upon completion of Sections 1 and 2 by the parent/guardian; Sections 3, 4, and 5 by the student and parent/guardian; and Section 6 by an Authorized Medical Examiner (AME), those Sections must be turned in to the Principal, or the Principal's designee, of the student's school for retention by the school. The CIPPE may not be authorized earlier than June 1st and shall be effective, regardless of when performed during a school year, until the latter of the next May 31st or the conclusion of the current spring sports season.

SUBSEQUENT SPORT(S) IN THE SAME SCHOOL YEAR: Following completion of a CIPPE, the same student seeking to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in subsequent sport(s) in the same school year, must complete Section 7 of this form and must turn in that Section to the Principal, or Principal's designee, of his or her school. The Principal, or the Principal's designee, will then determine whether Section 8 need be completed.

SECTION 1: PERSONAL AND EMERGENCY INFORMATION

PERSONAL INFORMATION
Student's Name ____________________________ Male/Female (circle one)

Date of Student's Birth: ___/___/_______ Age of Student on Last Birthday: ____ Grade for Current School Year: ___

Current Physical Address ____________________________

Current Home Phone # ( )___________ Parent/Guardian Current Cellular Phone # ( )___________

Fall Sport(s): __________________________ Winter Sport(s): __________________________ Spring Sport(s): __________________________

EMERGENCY INFORMATION
Parent's/Guardian's Name__________________________ Relationship _________

Address ____________________________ Emergency Contact Telephone # ( )___________

Secondary Emergency Contact Person’s Name__________________________ Relationship _________

Address ____________________________ Emergency Contact Telephone # ( )___________

Medical Insurance Carrier________________________________________ Policy Number____________________

Address ____________________________ Telephone # ( )___________

Family Physician’s Name_________________________________________, MD or DO (circle one)

Address ____________________________ Telephone # ( )___________

Student’s Allergies______________________________________________

Student’s Health Condition(s) of Which an Emergency Physician or Other Medical Personnel Should be Aware______________________________________________

______________________________________________

Student’s Prescription Medications and conditions of which they are being prescribed______________________________________________

______________________________________________

Revised: March 22, 2017
**SECTION 2: CERTIFICATION OF PARENT/GUARDIAN**

The student’s parent/guardian must complete all parts of this form.

A. I hereby give my consent for _________________________ born on _____________ who turned _____ on his/her last birthday, a student of _______________ School and a resident of the _________________________ public school district, to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests during the 20____-20____ school year in the sport(s) as indicated by my signature(s) following the name of the said sport(s) approved below.

<table>
<thead>
<tr>
<th>Fall Sports</th>
<th>Signature of Parent or Guardian</th>
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<tbody>
<tr>
<td>Cross Country</td>
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<tr>
<td>Field Hockey</td>
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<td>Football</td>
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<tr>
<td>Golf</td>
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<tr>
<td>Soccer</td>
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<tr>
<td>Girls’ Tennis</td>
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<tr>
<td>Girls’ Volleyball</td>
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<tr>
<td>Water Polo</td>
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<tr>
<td>Other</td>
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<table>
<thead>
<tr>
<th>Winter Sports</th>
<th>Signature of Parent or Guardian</th>
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<tbody>
<tr>
<td>Basketball</td>
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<tr>
<td>Bowling</td>
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<tr>
<td>Competitive Spirit Squad</td>
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<tr>
<td>Girls’ Gymnastics</td>
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<td>Rifle</td>
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<tr>
<td>Swimming and Diving</td>
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<tr>
<td>Track &amp; Field (Indoor)</td>
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<tr>
<td>Wrestling</td>
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<td>Other</td>
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<tr>
<th>Spring Sports</th>
<th>Signature of Parent or Guardian</th>
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<td>Baseball</td>
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<tr>
<td>Boys’ Lacrosse</td>
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<td>Girls’ Lacrosse</td>
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<td>Softball</td>
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<td>Boys’ Tennis</td>
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<td>Track &amp; Field (Outdoor)</td>
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<tr>
<td>Boys’ Volleyball</td>
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<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

B. Understanding of eligibility rules: I hereby acknowledge that I am familiar with the requirements of PIAA concerning the eligibility of students at PIAA member schools to participate in Inter-School Practices, Scrimmages, and/or Contests involving PIAA member schools. Such requirements, which are posted on the PIAA Web site at [www.piaa.org](http://www.piaa.org), include, but are not necessarily limited to age, amateur status, school attendance, health, transfer from one school to another, season and out-of-season rules and regulations, semesters of attendance, seasons of sports participation, and academic performance.

Parent’s/Guardian’s Signature __________________________________________ Date _____ / _____ / _____

C. Disclosure of records needed to determine eligibility: To enable PIAA to determine whether the herein named student is eligible to participate in interscholastic athletics involving PIAA member schools, I hereby consent to the release to PIAA of any and all portions of school record files, beginning with the seventh grade, of the herein named student specifically including, without limiting the generality of the foregoing, birth and age records, name and residence address of parent(s) or guardian(s), residence address of the student, health records, academic work completed, grades received, and attendance data.

Parent’s/Guardian’s Signature __________________________________________ Date _____ / _____ / _____

D. Permission to use name, likeness, and athletic information: I consent to PIAA’s use of the herein named student’s name, likeness, and athletically related information in video broadcasts and re-broadcasts, webcasts and reports of Inter-School Practices, Scrimmages, and/or Contests, promotional literature of the Association, and other materials and releases related to interscholastic athletics.

Parent’s/Guardian’s Signature __________________________________________ Date _____ / _____ / _____

E. Permission to administer emergency medical care: I consent for an emergency medical care provider to administer any emergency medical care deemed advisable to the welfare of the herein named student while the student is practicing for or participating in Inter-School Practices, Scrimmages, and/or Contests. Further, this authorization permits, if reasonable efforts to contact me have been unsuccessful, physicians to hospitalize, secure appropriate consultation, to order injections, anesthesia (local, general, or both) or surgery for the herein named student, I hereby agree to pay for physicians’ and/or surgeons’ fees, hospital charges, and related expenses for such emergency medical care. I further give permission to the school’s athletic administration, coaches and medical staff to consult with the Authorized Medical Professional who executes Section 6 regarding a medical condition or injury to the herein named student.

Parent’s/Guardian’s Signature __________________________________________ Date _____ / _____ / _____

F. CONFIDENTIALITY: The information on this CIPPE shall be treated as confidential by school personnel. It may be used by the school’s athletic administration, coaches and medical staff to determine athletic eligibility, to identify medical conditions and injuries, and to promote safety and injury prevention. In the event of an emergency, the information contained in this CIPPE may be shared with emergency medical personnel. Information about an injury or medical condition will not be shared with the public or media without written consent of the parent(s) or guardian(s).

Parent’s/Guardian’s Signature __________________________________________ Date _____ / _____ / _____
SECTION 3: UNDERSTANDING OF RISK OF CONCUSSION AND TRAUMATIC BRAIN INJURY

What is a concussion?
A concussion is a brain injury that:
- Is caused by a bump, blow, or jolt to the head or body.
- Can change the way a student’s brain normally works.
- Can occur during Practices and/or Contests in any sport.
- Can happen even if a student has not lost consciousness.
- Can be serious even if a student has just been “dinged” or “had their bell rung.”

All concussions are serious. A concussion can affect a student’s ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most students with a concussion get better, but it is important to give the concussed student’s brain time to heal.

What are the symptoms of a concussion?
Concussions cannot be seen; however, in a potentially concussed student, one or more of the symptoms listed below may become apparent and/or that the student “doesn’t feel right” soon after, a few days after, or even weeks after the injury.
- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

What should students do if they believe that they or someone else may have a concussion?
- Students feeling any of the symptoms set forth above should immediately tell their Coach and their parents. Also, if they notice any teammate evidencing such symptoms, they should immediately tell their Coach.
- The student should be evaluated. A licensed physician of medicine or osteopathic medicine (MD or DO), sufficiently familiar with current concussion management, should examine the student, determine whether the student has a concussion, and determine when the student is cleared to return to participate in interscholastic athletics.
- Concussed students should give themselves time to get better. If a student has sustained a concussion, the student’s brain needs time to heal. While a concussed student’s brain is still healing, that student is much more likely to have another concussion. Repeat concussions can increase the time it takes for an already concussed student to recover and may cause more damage to that student’s brain. Such damage can have long term consequences. It is important that a concussed student rest and not return to play until the student receives permission from an MD or DO, sufficiently familiar with current concussion management, that the student is symptom-free.

How can students prevent a concussion? Every sport is different, but there are steps students can take to protect themselves.
- Use the proper sports equipment, including personal protective equipment. For equipment to properly protect a student, it must be:
  - The right equipment for the sport, position, or activity;
  - Worn correctly and the correct size and fit; and
  - Used every time the student Practices and/or competes.
- Follow the Coach’s rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.

If a student believes they may have a concussion: Don’t hide it. Report it. Take time to recover.

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Student’s Signature __________________________________________ Date __/__/____

I hereby acknowledge that I am familiar with the nature and risk of concussion and traumatic brain injury while participating in interscholastic athletics, including the risks associated with continuing to compete after a concussion or traumatic brain injury.

Parent’s/Guardian’s Signature __________________________________________ Date __/__/____
What is sudden cardiac arrest?

Sudden cardiac arrest (SCA) is when the heart stops beating, suddenly and unexpectedly. When this happens blood stops flowing to the brain and other vital organs. SCA is NOT a heart attack. A heart attack may cause SCA, but they are not the same. A heart attack is caused by a blockage that stops the flow of blood to the heart. SCA is a malfunction in the heart’s electrical system, causing the heart to suddenly stop beating.

How common is sudden cardiac arrest in the United States?

There are about 300,000 cardiac arrests outside hospitals each year. About 2,000 patients under 25 die of SCA each year.

Are there warning signs?

Although SCA happens unexpectedly, some people may have signs or symptoms, such as:

- dizziness
- lightheadedness
- shortness of breath
- difficulty breathing
- racing or fluttering heartbeat (palpitations)
- syncope (fainting)
- fatigue (extreme tiredness)
- weakness
- nausea
- vomiting
- chest pains

These symptoms can be unclear and confusing in athletes. Often, people confuse these warning signs with physical exhaustion. SCA can be prevented if the underlying causes can be diagnosed and treated.

What are the risks of practicing or playing after experiencing these symptoms?

There are risks associated with continuing to practice or play after experiencing these symptoms. When the heart stops, so does the blood that flows to the brain and other vital organs. Death or permanent brain damage can occur in just a few minutes. Most people who have SCA die from it.

Act 59 – the Sudden Cardiac Arrest Prevention Act (the Act)

The Act is intended to keep student-athletes safe while practicing or playing. The requirements of the Act are:

Information about SCA symptoms and warning signs.

- Every student-athlete and their parent or guardian must read and sign this form. It must be returned to the school before participation in any athletic activity. A new form must be signed and returned each school year.
- Schools may also hold informational meetings. The meetings can occur before each athletic season. Meetings may include student-athletes, parents, coaches and school officials. Schools may also want to include doctors, nurses, and athletic trainers.

Removal from play/return to play

- Any student-athlete who has signs or symptoms of SCA must be removed from play. The symptoms can happen before, during, or after activity. Play includes all athletic activity.
- Before returning to play, the athlete must be evaluated. Clearance to return to play must be in writing. The evaluation must be performed by a licensed physician, certified registered nurse practitioner, or cardiologist (heart doctor). The licensed physician or certified registered nurse practitioner may consult any other licensed or certified medical professionals.

I have reviewed and understand the symptoms and warning signs of SCA.

Signature of Student-Athlete

Print Student-Athlete’s Name

Date / / 

Signature of Parent/Guardian

Print Parent/Guardian’s Name

Date / / 
SECTION 5: HEALTH HISTORY

Explain “Yes” answers at the bottom of this form. Circle questions you don’t know the answers to.

1. Has a doctor ever denied or restricted your participation in sport(s) for any reason? [ ] Yes [ ] No
2. Do you have an ongoing medical condition (like asthma or diabetes)? [ ] Yes [ ] No
3. Are you currently taking any prescription or nonprescription (over-the-counter) medicines or pills? [ ] Yes [ ] No
4. Do you have allergies to medicines, pollen, foods, or stinging insects? [ ] Yes [ ] No
5. Have you ever had out or nearly passed out during exercise? [ ] Yes [ ] No
6. Have you ever passed out or nearly passed out after exercise? [ ] Yes [ ] No
7. Have you ever had discomfort, pain, or pressure in your chest during exercise? [ ] Yes [ ] No
8. Does your heart race or skip beats during exercise? [ ] Yes [ ] No
9. Has a doctor ever told you that you have (check all that apply):
   [ ] High blood pressure [ ] Heart murmur
   [ ] High cholesterol [ ] Heart infection
10. Has a doctor ever ordered a test for your heart? (for example ECG, echocardiogram) [ ] Yes [ ] No
11. Has anyone in your family died from no apparent reason? [ ] Yes [ ] No
12. Does anyone in your family have a heart problem? [ ] Yes [ ] No
13. Has any family member or relative been disabled from heart disease or died of heart problems or sudden death before age 50? [ ] Yes [ ] No
14. Does anyone in your family have Marfan syndrome? [ ] Yes [ ] No
15. Have you ever spent the night in a hospital? [ ] Yes [ ] No
16. Have you ever had surgery? [ ] Yes [ ] No

17. Have you ever had an injury, like a sprain, muscle, or ligament tear, or tendonitis, which caused you to miss a practice or contest? If yes, circle affected area below:
   [ ] Head
   [ ] Neck
   [ ] Shoulder
   [ ] Upper arm
   [ ] Elbow
   [ ] Forearm
   [ ] Hand
   [ ] Finger
   [ ] Ankle
   [ ] Foot
   [ ] Hip
   [ ] Knee
   [ ] Calf/ shin
   [ ] Instability
   [ ] Cast, or crutches? If yes, circle below:

18. Have you had any broken or fractured bones or dislocated joints? If yes, circle below:
[ ] Yes [ ] No

19. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, a cast, or crutches? If yes, circle below:
[ ] Yes [ ] No

20. Have you ever had a stress fracture? [ ] Yes [ ] No
21. Have you been told that you have or have had an x-ray for atlantoaxial (neck) instability? [ ] Yes [ ] No
22. Do you regularly use a brace or assistive device? [ ] Yes [ ] No

23. Has a doctor ever told you that you have asthma or allergies? [ ] Yes [ ] No
24. Do you cough, wheeze, or have difficulty breathing during or after exercise? [ ] Yes [ ] No
25. Is there anyone in your family who has asthma? [ ] Yes [ ] No
26. Have you ever used an inhaler or taken asthma medicine? [ ] Yes [ ] No
27. Were you born without or are you missing a kidney, an eye, a testicle, or any other organ? [ ] Yes [ ] No
28. Have you had infectious mononucleosis (mono) within the last month? [ ] Yes [ ] No
29. Do you have any rashes, pressure sores, or other skin problems? [ ] Yes [ ] No
30. Have you ever had a herpes skin infection? [ ] Yes [ ] No

CONCUSSION OR TRAUMATIC BRAIN INJURY
31. Have you ever had a concussion (i.e. bell rung, ding, head rush) or traumatic brain injury? [ ] Yes [ ] No
32. Have you been hurt in the head and been confused or lost your memory? [ ] Yes [ ] No
33. Do you experience dizziness and/or headaches with exercise? [ ] Yes [ ] No

34. Have you ever had a seizure? [ ] Yes [ ] No
35. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling? [ ] Yes [ ] No
36. Have you ever been unable to move your arms or legs after being hit or falling? [ ] Yes [ ] No
37. When exercising in the heat, do you have severe muscle cramps or become ill? [ ] Yes [ ] No
38. Has a doctor told you that you or someone in your family has sickle cell trait or sickle cell disease? [ ] Yes [ ] No
39. Have you had any problems with your eyes or vision? [ ] Yes [ ] No
40. Do you wear glasses or contact lenses? [ ] Yes [ ] No
41. Do you wear protective eyewear, such as goggles or a face shield? [ ] Yes [ ] No
42. Are you unhappy with your weight? [ ] Yes [ ] No
43. Are you trying to gain or lose weight? [ ] Yes [ ] No
44. Has anyone recommended you change your weight or eating habits? [ ] Yes [ ] No
45. Do you limit or carefully control what you eat? [ ] Yes [ ] No
46. Do you have any concerns that you would like to discuss with a doctor? [ ] Yes [ ] No

FEMALES ONLY
47. Have you ever had a menstrual period? [ ] Yes [ ] No
48. How old were you when you had your first menstrual period? [ ] [ ] [ ]
49. How many periods have you had in the last 12 months? [ ] [ ] [ ]
50. Are you pregnant? [ ] Yes [ ] No

#’s

Explain “Yes” answers here:

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Student’s Signature __________________________ Date _____/____/____

I hereby certify that to the best of my knowledge all of the information herein is true and complete.

Parent’s/Guardian’s Signature __________________________ Date _____/____/____
**SECTION 6: PIAA COMPREHENSIVE INITIAL PRE-PARTICIPATION PHYSICAL EVALUATION AND CERTIFICATION OF AUTHORIZED MEDICAL EXAMINER**

Must be completed and signed by the Authorized Medical Examiner (AME) performing the herein named student’s comprehensive initial pre-participation physical evaluation (CIPPE) and turned in to the Principal, or the Principal’s designee, of the student’s school.

Student’s Name ___________________________ Age ________ Grade ______

Enrolled in ______________________________ School  Sport(s) __________________

Height ______ Weight ______ % Body Fat (optional) _______ Brachial Artery BP ______/____ (_____ / ____ . ____ / ____ ) RP ______

If either the brachial artery blood pressure (BP) or resting pulse (RP) is above the following levels, further evaluation by the student’s primary care physician is recommended.

**Age 10-12:** BP: >126/82, RP: >104; **Age 13-15:** BP: >136/86, RP >100; **Age 16-25:** BP: >142/92, RP >96.

Vision: R 20/____ L 20/____ Corrected: YES  NO (circle one)  Pupils: Equal  Unequal ______

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<thead>
<tr>
<th>MEDICAL</th>
<th>NORMAL</th>
<th>ABNORMAL FINDINGS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appearance</td>
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</tr>
<tr>
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<tr>
<td>Hearing</td>
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<td>Lymph Nodes</td>
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<tr>
<td>Leg/Ankle</td>
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<td>Foot/Toes</td>
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I hereby certify that I have reviewed the HEALTH HISTORY, performed a comprehensive initial pre-participation physical evaluation of the herein named student, and, on the basis of such evaluation and the student’s HEALTH HISTORY, certify that, except as specified below, the student is physically fit to participate in Practices, Inter-School Practices, Scrimmages, and/or Contests in the sport(s) consented to by the student’s parent/guardian in Section 2 of the PIAA Comprehensive Initial Pre-Participation Physical Evaluation form:

[ ] CLEARED  [ ] CLEARED, with recommendation(s) for further evaluation or treatment for:

[ ] NOT CLEARED for the following types of sports (please check those that apply):

[ ] COLLISION  [ ] CONTACT  [ ] NON-CONTACT  [ ] STRENUEOUS  [ ] MODERATELY STRENUEOUS  [ ] NON-STRENUEOUS

Due to ______________________________________

Recommendation(s)/Referral(s) ____________________________

AME’s Name (print/type) __________________________ License # ____________

Address ______________________________________ Phone (______) __________

AME’s Signature ___________________________ MD, DO, PAC, CRNP, or SNP (circle one) Certification Date of CIPPE _____/____/_____
MANDATORY HIPAA FORM FOR ALL ATHLETES

All student athletes and their parent/guardians are required to complete and return the following release form prior to being able to participate in athletics. This form will be required to ensure the Geisinger Sports Medicine Team is in compliance with the Health Insurance Portability and Accountability Act (HIPAA). (The athletic trainer is a hired employee of Geisinger.)

The HIPAA law was put into place to ensure the confidentiality of individuals requiring medical care. Every athlete has their individual rights protected for medical records. There must be a signed authorization form permitting the athletic trainer (employed by Geisinger) to disclose protected health information about the student athlete to the coaching staff. This would include the injury specifics, severity of the injury, and the status of the athlete’s return to play.

In order for your son/daughter to be able to participate in athletics, a copy of this form will need to be on file at the school. This form will only need to be completed one time per year prior to the start of the sport season. These forms will be available along with the physical forms in the main office and nurse’s office.

The Geisinger Sports Medicine Team appreciates your help in ensuring that this form is completed and returned prior to your son/daughters sports season.

Lora Chronowski, MS, LAT, ATC
Geisinger Sports Medicine Team
www.geisingersportsmed.com
lachronowski@geisinger.edu
**AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

**GEISINGER EMPLOYEE USE ONLY**

- Geisinger Medical Center
  100 N. Academy Avenue
  Danville, PA 17822

- Geisinger Wyoming Valley Medical Center
  1000 E. Mountain Boulevard
  Wilkes-Barre, PA 18711

- Geisinger Clinic (GMG)

**AS APPLICABLE**

I authorize an appropriate workforce member of the above entity(ies) to release information from my medical record to:

- Officials of the school that I (Student Athlete) attend.
- This would include, the coaching staff, athletic directors, insurance carriers and health-care professionals who are involved with my participation in interscholastic athletics.

- Lake Lehman School District
  Market Street
  PO BOX 38 Lehman, PA 18627

- Geisinger Wyoming Valley Medical Center
  1000 E. Mountain Boulevard
  Wilkes-Barre, PA 18711

**NOTE:** If patient is under 14 years of age and is not an emancipated minor the parent or guardian must sign.

**SPECIFIC INFORMATION TO RELEASE:**

- Discharge Summary
- History & Physical
- Consultation Report(s)
- Operation Report(s)
- Catheterization Report
- Clinic Notes
- Emergency Room Notes
- Laboratory Report(s)
- Pathology Report(s)
- X-ray Report(s)
- X-ray Film(s)
- Itemized Bill(s)

**Other (specify):**
- All information concerning my health that impacts my ability to participate in interscholastic athletics.
- Information about injuries (such as sprains), surgeries, or medical conditions (such as asthma). This is to inform the above referenced people of my health-related limitations and abilities to continue to participate in interscholastic athletics.

**SPECIAL AUTHORIZATION (if applicable)**

- My evaluation, testing, diagnosis or treatment for alcoholism and/or drug abuse or dependence may be released to
- the recipient noted on the signed authorization.
- My evaluation, testing, diagnosis or treatment concerning my mental health/rehabilitation and/or neuro-psychological
- information may be released to the recipient noted on the signed authorization.
- My testing, diagnosis or treatment for HIV/AIDS may be released to the recipient noted on this signed authorization.

**AUTHORIZATION SIGNATURES**

**NOTE:** IF PATIENT IS UNDER 14 YEARS OF AGE AND IS NOT AN EMANCIPATED MINOR THE PARENT OR GUARDIAN MUST SIGN.

**Date:** ___________________  **Patient Signature:** ___________________

**Date:** ___________________  **Witness Signature:** ___________________

If patient is unable to sign authorization form because of physical condition or age, complete the following:

**Patient is a minor or patient is unable to sign authorization because:**

**Date:** ___________________  **Signature:** ___________________  **(Parent/legal or personal representative)**  **Relationship:** ___________________

**Date:** ___________________  **Witness Signature:** ___________________

********COPY OF COMPLETED AUTHORIZATION FORM MUST BE GIVEN TO PATIENT******

**Copy:** Medical Record  **Copy:** Patient

#A-560-008-DMR ADDRESSOGRAPH  Rev. 5/03js  MRPC Approved: 6/03  Stores Item # 1091280
Lake-Lehman School District
Athletic Training Department

Emergency Contact Information

This form MUST be filled out by a parent or guardian of the student-athlete participating in athletics in the Lake-Lehman School District. Failure to do so will result in your son or daughter being held out of ALL sport activities until it is handed in.

Student-Athlete’s Name: _________________________________________  Grade: ________________
Parent or Guardian Name: ______________________________________________
Address: _____________________________________________________________________________
  Street  City  State  Zip Code
Parent or Guardian’s Home/Cell Phone Number: _____________________________________________
Parent or Guardian’s Work Phone Number: _________________________________________________
Additional Emergency Contact Name and Number: ____________________________________________

List the Student-Athlete’s allergies: ______________________________________________________
List the Student- Athlete’s Medical Conditions/Issues: _______________________________________
List emergency medications Student- Athlete is required to carry (ex.EPIPEN, Insulin, inhaler):
____________________________________________________________________________________
____________________________________________________________________________________
I understand that my student-athlete is responsible for carrying their emergency medications during after school activities and events (ex.games, practices). I hereby agree to allow the athletic trainer or coach to call emergency medical services (ex.911) in the event my son or daughter is injured and I am not present. The information above will only be used in these cases to facilitate the health care process.

Parent or Guardian Signature: ____________________________________________________________
Sport(s) Student-Athlete is participating in: ________________________________________________