ALABAMA HIGH SCHOOL ATHLETIC ASSOCIATION

Preparticipation Physical Evaluation Form

History

Name_____ Sex _____ Age_____ Date_____

Address _____ Date of birth _____

School _____ Grade _____ Phone_____

Sport _____

Explain "Yes" answers below:	Yes	No
1. Has a doctor ever restricted/denied your participation in sports?	☐	☐
2. Have you ever been hospitalized or spent a night in a hospital?	☐	☐
Have ever had surgery?	☐	☐
3. Do you have any ongoing medical conditions (like Diabetes or Asthma)?	☐	☐
4. Are you presently taking any medications or pills (prescription or over-the-counter?	☐	☐
5. Do you have any allergies (medicine, pollens, foods, bees or other stinging insects)?	☐	☐
6. Have you ever passed out during or after exercise?	☐	☐
Have you ever been dizzy during or after exercise?	☐	☐
Have you ever had chest pain or discomfort in your chest during or after exercise?	☐	☐
Do you tire more quickly than your friends during exercise?	☐	☐
Have you ever had high blood pressure?	☐	☐
Have you ever been told that you have a heart murmur, high cholesterol, or heart infection?	☐	☐
Have you ever had racing of your heart or skipped heartbeats?	☐	☐
Has anyone in your family died of heart problems or a sudden death before age 50?	☐	☐
Does anyone in your family have a heart condition?	☐	☐
Has a doctor ever ordered a test on your heart (EKG, echocardiogram)?	☐	☐
7. Do you have any skin problems (itching, rashes, staph, MRSA, acne)?	☐	☐
8. Have you ever had a head injury or concussion?	☐	☐
Have you ever been knocked out or unconscious?	☐	☐
Have you ever had a seizure?	☐	☐
Have you ever had a stinger, burner, pinched nerve, or loss of feeling or weakness in your arms or legs?	☐	☐
9. Have you ever had heat or muscle cramps?	☐	☐
Have you ever been dizzy or passed out in the heat?	☐	☐
10. Do you have trouble breathing or do you cough during or after activity?	☐	☐
Do you take any medications for asthma (for instance, inhalers)?	☐	☐
11. Do you use any special equipment (pads, braces, neck rolls, mouth guard, eye guards, etc.)?	☐	☐
12. Have you had any problems with your eyes or vision?	☐	☐
Do you wear glasses or contacts or protective eye wear?	☐	☐
13. Have you had any other medical problems (infectious mononucleosis, diabetes, infectious diseases, etc.)?	☐	☐
14. Have you had a medical problem or injury since your last evaluation?	☐	☐
15. Have you ever been told you have sickle cell trait?	☐	☐
Has anyone in your family had sickle cell disease or sickle cell trait?	☐	☐
16. Have you ever sprained/strained, dislocated, fractured, broken or had repeated swelling or other injuries of any bones or joints? ☐ Head ☐ Back ☐ Shoulder ☐ Forearm ☐ Hand ☐ Hip ☐ Knee ☐ Ankle ☐ Neck ☐ Chest ☐ Elbow ☐ Wrist ☐ Finger ☐ Thigh ☐ Shin ☐ Foot	☐	☐
17. When was your first menstrual period?_____ When was your last menstrual period?_____ What was the longest time between your periods last year?_____		
Explain "Yes" answers: _____ _____ _____ _____		

I hereby state that, to the best of my knowledge, my answers to the above questions are correct.

Signature of athlete _____ Date _____

Signature of parent/guardian _____

DUPLICATE AS NEEDED

Preparticipation Physical Evaluation

Rule 1, Sec. 14 — In order for a student to be eligible for interscholastic athletics, there must be on file in the Superintendent's or Principal's office a current physician's statement certifying that the student has passed a physical exam, and that in the opinion of the examining physician (M.D. or D.O.) the student is fully able to participate in interscholastic athletics (Grade s 7-12). The AHSAA Physicians Certificate (Form 5) must be used. A physical exam will satisfy the requirement for one calendar year from the date of the exam.

Physical Examination

COMPLETE	LIMITED	Height _____ Weight _____ BP ____ / ____ Pulse _____ Vision R 20 / ____ L 20 / ____ Corrected: Y N		
			Normal	Abnormal Findings
		Cardiovascular		
		Pulses		
		Heart		
		Lungs		
		Skin		
		E.N.T.		
		Abdominal		
		Genitalia (males)		
		Musculoskeletal		
		Neck		
		Shoulder		
		Elbow		
		Wrist		
		Hand		
		Back		
		Knee		
		Ankle		
		Foot		
		Other		

Clearance:

A. Cleared

B. Cleared after completing evaluation/rehabilitation for: _____

C. Not cleared for: ☐ Collision
☐ Contact
☐ Noncontact ____ Strenuous ____ Moderately strenuous ____ Nonstrenuous

Due to: _____

Recommendation: _____

_____

_____

Name of physician _____ Date _____

Address _____ Phone _____

Signature of physician _____, M.D. or D.O.

Jackson Hospital & Clinic, Inc.
Notice of Privacy Practices
3/31/2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions, please **contact our Privacy Office** at the address or telephone number at the bottom of this notice.

Who will follow this notice
Jackson Hospital & Clinic provides health care to our patients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by all departments and units of our organization, including all off-campus units or departments, and all employed associates, staff or volunteers of our organization, including staff at Jackson Hospital Owned Physician Offices.

In addition, we are a clinically integrated care setting, and we have many doctors and other providers giving care to patients in our Hospital. For convenience of our patients, we are giving one Notice of Privacy Practices to each patient, instead of notices from multiple physicians and other caregivers. This Notice serves as the notice required under Federal law to be given to patients by this Hospital, all members of our Hospital medical staff and all other health care professionals who treat you at any of our locations. The health care providers covered by this "organized health care arrangement" ("OHCA") will share protected health information with each other, as necessary to carry out your treatment, payment for treatment, and health care operations relating to the OHCA. This arrangement does not mean that the persons participating in the OHCA are involved in a joint business arrangement, or that they are responsible for the acts of one another.

Our pledge to you
As a patient at Jackson Hospital, you have the right to privacy concerning your medical plan of care. Medical record information and your relationship with your physician are considered private. Your diagnosis and course of treatment are available only to those directly involved with your care. Unless you tell us otherwise, we will make every effort to give your family continuous updates on your condition. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff or your doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep medical information about you private.
- Give you this Notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

Changes to this notice
We reserve the right change the terms of this Notice at any time. Changes will apply to medical information we already hold, as well as new information we receive after the change occurs. If we change our Notice, we will post the new Notice in waiting areas, patient rooms, and on our Web site at www.jackson.org. You can receive a copy of the current Notice at any time. The effective date is listed just below the title above. You will be offered a copy of the current Notice each time you register at a facility for treatment. You will also be asked to acknowledge in writing your receipt of this Notice on our General Consent for Treatment form.

How we may use and disclose medical information about you

- We may use and disclose medical information about you for **treatment** (such as sending medical information about you to a specialist as part as a referral); **to obtain payment for treatment** (such as sending billing information to your insurance company or Medicare); and **to support our health care operations** (such as comparing patient data to improve treatment methods). We may disclose medical information to "business associates" who provide contracted services such as accounting, legal representation, claims processing, accreditation, and consulting. If we do disclose medical information to a business associate, we will do so subject to a contract that provides that the information will be kept confidential, within the timeframes required by HIPAA of 1996.

- We may use or disclose information about you **without** your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for **public health purposes (such as reports of communicable diseases, births and deaths), abuse or neglect reporting, government health oversight audits or inspections, research studies (under some circumstances), funeral arrangements and organ donation, workers' compensation purposes, and emergencies.** We will also disclose medical information **when required by law**, such as in response to a request from law enforcement in specific circumstances, or in response to valid judicial or administrative orders.

- We also may contact you for **appointment reminders**, to tell you about or recommend **possible treatment options, alternatives, health-related benefits or services** that may be of interest to you, or to raise funds for the Hospital.

- If you are admitted as a patient, unless you tell us otherwise, we will list in the patient directory your name, location in the hospital, your general condition (good, fair, etc.) and your religious affiliation, and will release all but your religious affiliation to anyone who asks about you by name. Your religious affiliation may be disclosed to a clergy member, even if they do not ask for you by name. You can ask us to restrict some of all of the information in the directory, and to whom it is given.

- If you do not object, we may disclose medical information about you to a friend or family member who is involved in your medical care. We may also release information to disaster relief authorities, so that your family can be notified of your location and condition.

Other uses of medical information
In any other situation not covered by this Notice or the laws that apply to us, we will ask for your written authorization before using or disclosing medical information about you. If you authorize a use or disclosure, you can revoke that authorization at any time by notifying us in writing of your decision. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Your rights regarding medical information about you

- In most cases, **you have the right to look at or get a copy of medical information** that we use to make decisions about your care, when you submit a written request. If you request copies, we may charge a fee for the cost of copying, mailing or other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for a review of that decision.

- If you believe that information in your records is incorrect or incomplete, you **have the right to request that we amend the records**, by submitting a request in writing that provides your reason for requesting the amendment. We may deny your request. You may appeal, in writing, a decision by us not to amend a record.

- **You have the right to a list of those instances where we have disclosed medical information about you,** other than for treatment, payment, health care operations or in some circumstances where you specifically authorized a disclosure, when you submit a written request. The request must state the time period desired for the accounting, which must be less than a 6-year period and starting after April 14, 2003. You may receive the list in paper or electronic form. The first disclosure list request in a 12-month period is free; other requests will be charged according to our cost of producing the list. We will inform you of the cost before you incur any costs.

- If this Notice was sent to you electronically, you **have the right to a paper copy of this Notice.**

- **You have the right to request that medical information about you be communicated to you in a confidential manner,** such as sending mail to an address other then your home, by notifying us in writing of the specific way or location for us to use to communicate with you.

- **You may request, in writing, that we do not use or disclose medical information about you,** for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law or in an emergency. We will consider your request **but we are not legally required to accept it.** We will inform you of our decision on your request. All written requests or appeals should be submitted to our Privacy Office listed at the bottom of this notice.

Complaints
If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Privacy Office at this address:

Jackson Hospital Privacy Office
1725 Pine Street, Montgomery, AL 36106
Telephone: 334-293-8799

All complaints must be submitted in writing. You may also send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Our Privacy Office can provide you the address. Under no circumstances will you be penalized or retaliated against for filing a complaint.

Alabama Christian Academy Band Student Authorization
For
Disclosure of Protected Health Information

I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Jackson Hospital Sports Medicine to release information regarding the band student's protected health information and related information regarding any injury or illness while participating in band related activities at Alabama Christian Academy. I further understand that it is at my request to comply with the requirements of his/her school and the release of protected health information to a band director or school official in connection with participation in all band related activities marching or otherwise. This protected health information may concern the band student's medical status, medical condition, injuries, prognosis, diagnosis, participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospital and/or medical clinics and laboratories, band directors, medical insurance coordinators or school administrators.

I _____ parent or guardian of _____

(name of parent/legal guardian) (name of student band member)

understand that as a parent/legal guardian give authorization for the disclosure of my band student's protected health information is a condition for participation as a marching band member at Alabama Christian Academy for the purpose of the undersigned band student to participate in all marching band related activities. I understand that my protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that once information is disclosed per authorization or consent, the information is subject to re-disclosure and may no longer be protected by HIPAA and/or the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization/consent at any time by notifying in writing to the school's band director(s), but if I do, it will not have any effect on the actions that Alabama Christian Academy school officials take in reliance on this authorization/consent prior to receiving the revocation. This authorization/consent expires on year from the date it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION IN ALL MARCHING BAND ACTIVITIES

_____ _____

Print Band Member's Name Signature of Parent/Legal Guardian

_____

Date

MARCHING BAND TRAVEL PERMIT

I hereby give my consent for _____ to travel to and from athletic events scheduled by Alabama Christian Academy as well as competitions scheduled by the ACA Marching Band. I understand the music department policy will be to provide transportation by school bus, van or chartered bus when possible, but transportation for home games and local games will be by private transportation in personal cars; some of which may be driven by band members and/or parents. Out of town games/competitions may also utilize private vehicles but it will be school policy that they be driven by adults. By signing below I am giving my permission for my child to ride with other drivers and I agree to hold harmless Alabama Christian, board members, employees, drivers and/or parents of drivers responsible for any accident, injury, or death that may occur.

Date _____ Parent / Guardian Signature _____

Emergency Information

Student Name: _____ Date of Birth ____/____/____

Student Social Security Number: ____-____-____

Parent Name: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Address: _____
Street City Zip Code

Name of Emergency Contact Person: _____

Relationship: _____ Home Phone: _____

Work Phone: _____

The following information is very important to have on file in case of emergency situations. Please fill in the information to the best of your abilities. Please list any insurance coverage, including Champus, Medicare, Medicaid, accident policies, HMO'S ect. If you do not have insurance coverage please check the "NO Insurance" box.

INSURANCE COMPANY: _____

INSURANCE ADDRESS: _____
Street

_____
City State Zip

NAME OF INSURED: _____
Last First M.I.

RELATIONSHIP: _____ PHONE: _____

INSURED SSN: ____-____-____ FAMILY PHYSICIAN: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

Please check the proper insurance type if applicable

HMO[ ] PPO[ ] No Insurance [ ] Medicaid/Medicare [ ]

If you are covered by an HMO or PPO insurance, you MUST go through your primary care physician to receive treatment.

Attest that I have answered the above questions to the best of my ability and recognize the importance of fully and accurately disclosing the above information.

Parent/Guardian Signature: _____ Date: _____

Jackson Hospital Sports Medicine is a cooperative effort between Jackson Hospital & Clinic Rehab Associates, and Alabama Orthopedic Specialists. The following release statements and information requires the signature of a parent/legal guardian. The parent/legal guardians signature is a **REQUIREMENT and considered a condition to play interscholastic sports at Alabama Christian Academy.**

Notice of Privacy Practices

Jackson Hospital Sports Medicine is a cooperative effort between Jackson Hospital & Clinic Rehab Associates, and Alabama Orthopedic Specialists. Jackson Hospital Sports Medicine is an Organize Health Care Agreement as, defined by the Health information Portability Accountability Act. I have, received the Jackson Hospital Sports Medicine Notice of Privacy Practices and I understand my rights under HIPAA.

_____ _____

Parent/Legal Guardian Signature Date

Catastrophic Injury Waiver

The possibility of sustaining a catastrophic injury in inherent in any athletic activity.

I _____, understand that by participating in athletics at Alabama
(Student Athlete Name)

Christian Academy, the potential of a catastrophic injury does not exist. With this fact in mind, I understand the importance of rules and procedures as well as necessity of using proper techniques. Furthermore, I understand that the possibility of a catastrophic injury does exist even though the above statements are followed to the fullest.

_____ _____

Student Signature Date

_____ _____

Parent/ Legal Guardian Signature Date

Consent to Treat and Care

I _____, parent or guardian of _____ recognize that as a result of athletic participation, medical treatment on an emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby authorize in advance to such emergency care, including hospital care, as may be deemed necessary under tbe then existing circumstances. The purpose of this release is to authorize the school to obtain, through a physician of i-:s choice, any emergency medical care that may become reasonably necessary for the student in the course of school athletic activities or school travel.

_____ _____

Parent/ Legal Guardian Signature Date