

West Allis – West Milwaukee School District
Nathan Hale Athletic Department
Emergency Care Form

Athlete's Name _____ Birth Date ____ / ____ / ____

Sport(s) or Activity _____

Grade _____ Male _____ Female _____ Home Phone # _____

Parent / Guardian Name _____

Home Address _____ Email _____

Work Phone # _____ Cell Phone # _____

In case of an emergency and you are unable to be reached, please list an alternative contact.

Name _____ Relationship _____

Work/Home Phone # _____ Cell Phone # _____

Medical History

Please list any know allergies _____

Please list any medications the student athlete is currently taking _____

Please list any medical conditions the student athlete has (asthma, diabetes, etc) _____

Please list any previous injuries (ankle sprain, concussion, etc) _____

I hereby authorize the athletic training and staff of the Nathan Hale School Athletic Dept. (coaches, athletic trainer, and/or team physician) (Department) to provide and secure any medical assistance on behalf of my son/daughter. I further authorize these individuals to discuss my son/daughter's medical condition with other health care personnel which the Department deems appropriate.

I hereby indemnify and hold harmless the Department and entities and other persons who act in reliance upon this authorization.

Student Athlete Signature _____ Date ____ / ____ / ____

Parent/Guardian Signature _____ Date ____ / ____ / ____

HIPPA Form on back must be signed



EXHIBIT A - PARTICIPATION IN ATHLETIC TRAINING SERVICES

Name of Student Athlete

Birth Date

Address

Name of School

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for Wheaton Franciscan Healthcare to evaluate and furnish medical care and treatment as necessary through ATHLETIC TRAINING SERVICES for the above named student athlete. Additionally, I grant the athletic trainer's permission to share protected health information as required in medical care situations with other healthcare providers involved in the care of the student athlete.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned, do hereby acknowledge that Wheaton Franciscan Healthcare has provided to me a copy of Wheaton Franciscan Healthcare's Notice of Privacy Practices explaining:

- How we use and disclose your health information
- Your privacy rights with regard to your protected health information
- Our obligations to you concerning the use and disclosure of your protected health information

AUTHORIZATION FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, the undersigned, do hereby authorize the Wheaton Franciscan Healthcare Certified Athletic Training staff to use and disclose the protected health information of the above student athlete for purposes of participation in ATHLETIC TRAINING SERVICES. Protected health information will be used by those individuals participating in Athletic Training Services as well as the school's coaching staff, athletic director, and physical education faculty involved in sporting events.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION

Right to Receive Copy of This Authorization - I understand that if I agree to sign this authorization, I must be provided with a copy upon request. **Right to Refuse to Sign This Authorization** - I understand that I am under no obligation to sign this form. If I choose not to sign this form, it may limit my ability to participate in Athletic Training Services. **Right to Withdraw This Authorization** - I understand that I have the right to withdraw this authorization at any time by providing a written statement of withdrawal to Wheaton Franciscan Healthcare. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reference to this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected by Federal privacy standards.

EXPIRATION DATE

This authorization is good through the period of the above student's participation in the Wheaton Franciscan Healthcare Athletic Training Services and/or the period of the student's school enrollment.

I have had an opportunity to review and understand the content of this form. By signing this authorization, I am confirming that it accurately reflects my wishes.

SIGNATURE OF ADULT STUDENT/PARENT/LEGAL REPRESENTATIVE

Signature/Relationship

Date

