Sportsmedicine
FAIRBANKS

2009 - 2010 School Year

Dear Parents and Coaches:

Cary S. Keller, MD, FACSM and Sportsmedicine Fairbanks are pleased to provide the Fairbanks Community with Sportsmedicine and Orthopaedic quality care. The mission of ***Sportsmedicine Fairbanks*** is to provide quality attentive and interactive care which will return your athlete to their active lifestyle allowing them to expand their athletic horizons.

This packet of information contains the forms necessary for your student athlete to participate in Sports Physicals, as well as acquire care from the Certified Athletic Trainer, Team Physician and Medical Associates in your school.

- **Sportsmedicine Fairbanks Consent for Sports Physicals FNSBSD**
  - This form grants permission for Sportsmedicine Fairbanks, Adient Orthopedic Physical Therapy, Fairbanks Urgent Care Medical Providers and other community medical/clinical staff volunteers to conduct the Sports Physical for your student athlete for clearance for Sports Participation. Your signature also acknowledges the notification that these Sports Physicals are screening exams and are not intended to be a comprehensive exam, provide medical treatment or create a physician/patient relationship.

- **Consent for Treatment Form**
  - As parents or legal guardian of the student athlete you'll need to grant permission for treatment deemed necessary for a condition arising during or affecting participation in sports including medical or surgical treatment required by a medical doctor. This consent is blanket for the school year 2009 – 2010. You'll also need to grant permission to release medical information to the school officials (Coaches, Athletic Director, School Nurse, etc) as well as permission for the Athletic Trainer, Physician and emergency medical providers to acquire medical information regarding the athlete from other health care providers. This form acknowledges your acceptance of risk for the student to participate in interscholastic athletics.

- **Athlete Student Consent Release Hippa PHI Form**
  - As parents or legal guardian/representative of the student athlete you'll need to grant permission for the Athletic Trainer, Physician or Medical Provider Associates to release protected health care information as defined by the Federal HIPAA (Health Insurance Portability and Accountability Act of 1996) Regulations. A full copy of the HIPAA Privacy Notice is available upon your request. This form will authorize Medical Providers associated with the school to use and disclose the Sports Physical Clearance and health recommendations and assessments and treatment given throughout the year to the athlete's parents/legal guardians, other medical providers, athletic directors, coaches, athletic staff and medical personnel at the school/organization/team to inform them of the student athlete's health status for participation in athletics or activities, and for emergency medical treatment.

- **FNSBSD Physical Forms**
    - Parent or legal guardian must sign the physical form which is returned to the school/organization.

This packet of information has been furnished to you as a courtesy to you by ***Sportsmedicine Fairbanks.*** All forms must be completed and signed as a pre-requisite for Sports Physicals and for care provided by the Athletic Trainer and Physicians and Medical Providers associated with your student athlete's school.

Sportsmedicine Fairbanks is available by phone 24 hours a day at 451-6561. Please visit our web site at www.sportsmedicinefairbanks.com to learn more about our facility, our philosophy of medical care and our healthcare providers.

We look forward to responding to the needs of your athlete or yourself in our Sportsmedicine and Orthopaedic medical practice located at 751 Old Richardson Hwy, Ste #200 (next door to The Fairbanks Athletic Club/The Alaska Club). For your convenience, a second packet of registration documents has been included should you choose Sportsmedicine Fairbanks Clinic for medical care for your athlete, your family or yourself.

Warmest Regards,

Cary S. Keller, M.D., FACSM
Medical Director
Sportsmedicine Fairbanks

Sportsmedicine Fairbanks
751 Old Richardson Hwy, Ste 200
Fairbanks, AK 99701
(907) 451-6561 (907) 451-6564 Fax
www.sportsmedicinefairbanks.com

Dear Parent / Guardian,

It is our pleasure to provide Pre Season Sports Physicals and Musculoskeletal Screening for the athletes of the Fairbanks Community. We appreciate the opportunity to contribute this ***Sportsmedicine Fairbanks Outreach*** service. We are honored to support Fairbanks Athletes by providing this service and by returning the fees to support the Athletic Department. Please sign this form.

This gives your permission for, the Sportsmedicine Fairbanks team of volunteer physicians and staff, and other clinical volunteers from the community to provide this service for your child.

PARENTAL CONSENT FORM

This consent authorizes Sportsmedicine Fairbanks/Cary S. Keller, M.D., P.C., Sportsmedicine Fairbanks Medical Staff and other volunteer medical professionals from the community to conduct a Sports Physical screening exam for _____for the Season Assessment for Sports Activities within the Fairbanks North Star Borough School District and Interior Alaska.

I understand all medical providers are donating their time. I understand this is a Pre Season Sports Physical Screening Exam. It is not a comprehensive exam and it is not intended to provide treatment nor to create a physician/patient relationship. I understand that athletic participation comes with the risk of injury. This screening exam cannot detect all problems or prevent injury from athletic participation. I understand that if follow-up evaluation is recommended, it is my responsibility to seek care from an appropriate provider.

I certify I am the parent/legal guardian for this athlete/minor. I understand the information above.

_____
Signature of Parent/Guardian

_____
Date

_____
Athlete's Full Name Athlete's Date of Birth

_____
Athlete's Social Security Number

Parents Phone Number_____ Parent Home Phone Number _____
Parent Cell or pager Number _____
Alternative Contact Name and Number
_____

SPORTSMEDICINE FAIRBANKS
Lathrop High School
Athletic Training / Sports Medicine Department

Permission to Treat, Consent & Authorization for Release of Medical Records, and Acceptance of Risk Form

Student Athlete Name: _____ _____

PERMISSION FOR MEDICAL TREATMENT

Permission is hereby granted Christopher Dean, ATC, Head Athletic Trainer and other certified athletic trainers when the LHS Head Trainer is unavailable, and other trained medical professionals during emergencies to proceed with any medical treatment, either minor or emergency, deemed necessary in the event that the above named student-athlete sustains an injury/illness during participation in interscholastic athletics for Lathrop High School. This permission for medical treatment covers the period of the entire school year 2009 – 2010 terms through July 31, 2010 for all games, practices, activities, events, etc.

Permission is also hereby granted to the LHS Team Physician, Cary S. Keller, M.D., FACSM and/or other attending physicians and medical professionals to proceed with minor or emergency medical or surgical treatment for the previously named student-athlete. I understand that every effort will be made by the physician/medical professional to contact me prior to treatment.

CONSENT & AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Permission is hereby granted to Christopher Dean, ATC, Head Athletic Trainer, Team Physician Cary S. Keller, M.D., FACSM or any other medical consultant of Sportsmedicine Fairbanks to examine medical records concerning examination or treatment received by the above named student-athlete for the express purpose of evaluating a medical emergency or the medical or physical fitness for participation in, or continued participation in interscholastic athletics for Lathrop High School. Permission is also granted to furnish Sportmedicine Fairbanks and the Athletic Training / Sports Medicine Department at LHS with any reports or copies of the student athlete's medical records that the medical professional may request. I understand that these medical records may be shared with the athlete, his/her legal guardians/parents, other medical providers and LHS Athletic Trainers, Coaches, Athletic Director, and School Nurse in order to provide them with recommendations for, and to provide medical treatment to the student-athlete. I understand that information released may no longer be protected by state and federal privacy laws and regulations.

ACCEPTANCE OF RISK

We are aware of, and accept, the risk of injury associated with participation in interscholastic athletics for Lathrop High School. As a student-athlete, I will do my part to reduce the risk of injury by keeping myself in the best possible physical and mental condition and will follow the advice of the Team Physician, Athletic Trainer, and Coach concerning the prevention, evaluation, treatment, and rehabilitation of athletic injuries. I agree to be honest in my participation in athletics at LHS and to report any and all illegal activities to the appropriate authority.

Student-Athlete Signature: _____ Date: _____

Parent/Guardian/Legal Representative Signature _____ Date: _____

Parent/Guardian Phone Contact Numbers: Work _____ Home _____ Cell _____
Pager _____ Other _____ ***Please notify Trainer immediately if contact numbers change.***

PROTECTED HEALTH INFORMATION AUTHORIZATION

SPORTSMEDICINE FAIRBANKS

FOR RELEASE OF INFORMATION

The undersigned hereby authorize(s) any medical provider of the Athlete listed below, associated with his/her school/organization/team, specifically including the Clinic of *Sportsmedicine Fairbanks (SMF), Dr. Cary Keller, and other SMF Doctors, Athletic Trainers and Medical Providers,* to use and to disclose the Athlete's clearance and health records, information and recommendations to the Athlete's parents/legal guardians , other medical providers, athletic directors, coaches and medical personnel at the Athlete's school/organization/team to inform them of the Athlete's health status for participation in athletics or activities and to provide emergency medical treatment. I understand that my refusal to sign this authorization may affect the Athlete's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law.

Date:_____ Parent/Guardian Signature:_____

Printed Name:_____

Date:_____ Athlete's Signature if of legal age:_____

Athlete's Printed Name:_____