

FINAL FORMS™

REGISTERING A STUDENT

WHAT INFO WILL I NEED?

- Basic Medical History & Health Info
- Doctor, Dentist & Hospital Information
- Insurance Company & Policy Number
- Email Address for BOTH you and your student (if required by your district)

HOW DO I REGISTER MY FIRST STUDENT?

*****IMPORTANT***** If you have followed the steps on the previous page, you may Jump to Step 3.

1. Go to <https://northeastern-in.finalforms.com>



Parent

2. Click **LOGIN** under the Parent Icon



3. Click **REGISTER STUDENT**

My Students



4. Complete the form including the Student's Legal Name, **EMAIL ADDRESS**, Date of Birth, Gender, Graduation Year, Home Address and any other information required by your School District, then click **CREATE STUDENT**

NOTE: A student email address may or may not be required depending on your school district preferences. If so, the email address provided may be used to send reminders to your student.

5. **If your student plans to participate in a sport, activity, or club** please click the checkbox for each. Click **UPDATE** after making your selection.

NOTE: A selection can be changed any time until the registration deadline.

6. Complete each form and sign your full name (e.g. "John Smith") into the Parent Signature field at the bottom of the page. After signing, click **SUBMIT FORM** and move on to the next form.

Form Signatures

Parent Signature

Student Signature

Parent Signature

SUBMIT FORM

7. When all forms are complete, you will see a "Forms Finished" message.

*****IMPORTANT***** If required, an email will automatically be sent to the email address that you provided for your student prompting him/her to sign Student forms requiring his/her signature.

8. Click **MY STUDENTS** if you are done, or **REGISTER ANOTHER STUDENT** if you need to add another.

9. At any point in the future, you may login at any time and click the **UPDATE FORMS** button

FINALFORMS™

PARENT REGISTRATION

HOW DO I SIGN UP?



Parent

1. Go to <https://northeastern-in.finalforms.com>

2. Click **NEW ACCOUNT** under the Parent Icon



3. Type your **NAME**, **DATE OF BIRTH** and **EMAIL**, then click **REGISTER**

4. Check your Email for a FinalForms Email, and click **CONFIRM YOUR ACCOUNT** in the email text.

FINALFORMS

FinalForms ONLINE
Your FinalForms account was temporarily disabled because you have not been successfully verified.
Please visit the FinalForms user account page to complete your registration as a parent.
Thank you,
Northeastern Local Schools (NLS) Administration

NOTE: You will receive an email within 2 minutes prompting you to confirm and complete your registration. If you do not receive an email, check your spam folder. If you still do not see the FinalForms email, please email support@finalforms.com

5. Create your new FinalForms password and click **CONFIRM ACCOUNT**

You're almost done registering as a Parent

FinalForms ONLINE

Basic Password:

Confirm Password:

Confirm Account

6. You may be asked if you want to grant another Parent/Guardian access to your registered students. Either click **SKIP THIS STEP** or type the **NAME**, **DATE OF BIRTH** and **EMAIL**, then click **ADD PARENT ACCOUNT**.

Add Another Parent? [Skip this step](#)

FinalForms ONLINE

Name:

Date of Birth:

Month: Day: Year:

Email Address:

Add Parent Account Cancel

7. Your account(s) will be created, you can then click **REGISTER STUDENT** for your first child.

PREPARTICIPATION PHYSICAL EVALUATION HISTORY FORM



(Note: This form is to be filled out by the patient and parent prior to examination. The examiner should keep a copy of this form in the chart.)

Date of Exam _____
 Name _____ Date of birth _____
 Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

Do you have any allergies? Yes No If yes, please identify specific allergy below.
 Medicines Pollens Food Stinging Insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No	MEDICAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?			26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
2. Do you have any ongoing medical conditions? If so, please identify below: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infections Other: _____			27. Have you ever used an inhaler or taken asthma medicine?		
3. Have you ever spent the night in the hospital?			28. Is there anyone in your family who has asthma?		
4. Have you ever had surgery?			29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
HEART HEALTH QUESTIONS ABOUT YOU	Yes	No	30. Do you have groin pain or a painful bulge or hernia in the groin area?		
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?			31. Have you had infectious mononucleosis (mono) within the last month?		
6. Have you ever had discomfort, pain, lightheadedness, or pressure in your chest during exercise?			32. Do you have any rashes, pressure sores, or other skin problems?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?			33. Have you had a herpes or MRSA skin infection?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: <input type="checkbox"/> High blood pressure <input type="checkbox"/> A heart murmur <input type="checkbox"/> High cholesterol <input type="checkbox"/> A heart infection <input type="checkbox"/> Kawasaki disease Other: _____			34. Have you ever had a head injury or concussion?		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)			35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
10. Do you get lightheaded or feel more short of breath than expected during exercise?			36. Do you have a history of seizure disorder?		
11. Have you ever had an unexplained seizure?			37. Do you have headaches with exercise?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?			38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Yes	No	39. Have you ever been unable to move your arms or legs after being hit or falling?		
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?			40. Have you ever become ill while exercising in the heat?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?			41. Do you get frequent muscle cramps when exercising?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?			42. Do you or someone in your family have sickle cell trait or disease?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?			43. Have you had any problems with your eyes or vision?		
BONE AND JOINT QUESTIONS	Yes	No	44. Have you had any eye injuries?		
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?			45. Do you wear glasses or contact lenses?		
18. Have you ever had any broken or fractured bones or dislocated joints?			46. Do you wear protective eyewear, such as goggles or a face shield?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?			47. Do you worry about your weight?		
20. Have you ever had a stress fracture?			48. Are you trying to or has anyone recommended that you gain or lose weight?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)			49. Are you on a special diet or do you avoid certain types of foods?		
22. Do you regularly use a brace, orthotics, or other assistive device?			50. Have you ever had an eating disorder?		
23. Do you have a bone, muscle, or joint injury that bothers you?			51. Do you have any concerns that you would like to discuss with a doctor?		
24. Do any of your joints become painful, swollen, feel warm, or look red?			FEMALES ONLY		
25. Do you have any history of juvenile arthritis or connective tissue disease?			52. Have you ever had a menstrual period?		
			53. How old were you when you had your first menstrual period?		
			54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct.
 Signature of athlete _____ Signature of parent/guardian _____ Date _____

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PREPARTICIPATION PHYSICAL EVALUATION PHYSICAL EXAMINATION FORM



(The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) -- IHSAA By-Law 3-10

Name _____ Date of birth _____

PHYSICIAN REMINDERS

- Consider additional questions on more sensitive issues
 - Do you feel stressed out or under a lot of pressure?
 - Do you ever feel sad, hopeless, depressed, or anxious?
 - Do you feel safe at your home or residence?
 - Have you ever tried cigarettes, chewing tobacco, snuff, or dip?
 - During the past 30 days, did you use chewing tobacco, snuff, or dip?
 - Do you drink alcohol or use any other drugs?
 - Have you ever taken anabolic steroids or used any other performance supplement?
 - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
 - Do you wear a seat belt, use a helmet, and use condoms?
- Consider reviewing questions on cardiovascular symptoms (questions 5-14).

EXAMINATION		
Height	Weight	<input type="checkbox"/> Male <input type="checkbox"/> Female
BP / /	Pulse	Vision R 20/ L 20/ Corrected <input type="checkbox"/> Y <input type="checkbox"/> N
MEDICAL	NORMAL	ABNORMAL FINDINGS
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)†		
Skin • HSV lesions suggestive of MRSA, linea corporis		
Neurologic‡		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
 †Consider GU exam if in private setting. Having third party present is recommended.
 ‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion

- Cleared for all sports without restriction
- Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____
- Not cleared
- Pending further evaluation
 - For any sports
 - For certain sports: _____
- Reason _____

Recommendations _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians). (The physical examination must be performed on or after April 1 by a physician holding an unlimited license to practice medicine, a nurse practitioner or a physician assistant to be valid for the following school year.) -- IHSAA By-Law 3-10

Name of physician (print/type) (MD, DO, NP, or PA) _____ Date _____
 Address _____ Phone _____
 Signature of physician (MD, DO, NP, or PA) _____ License # _____



PRE-PARTICIPATION PHYSICAL EVALUATION FORM (PPE)

The IHSAA Pre-participation Physical Evaluation (PPE) is the first and most important step in providing for the well-being of Indiana's high school athletes. The form is designed to identify risk factors prior to athletic participation by way of a thorough medical history and physical examination. The IHSAA, under the guidance of the Indiana State Medical Association's Committee on Sports Medicine, requires that the PPE Form be signed by a physician (MD or DO) holding an unlimited license to practice medicine, a nurse practitioner (NP) or a physician assistant (PA). In order to assure that these rigorous standards are met, both organizations endorse the following requirements for completion of the PPE Form:

1. The most current version of the IHSAA PPE Form must be used and may not be altered or modified in any way.
(available for download at www.ihsaa.org<<http://www.ihsaa.org>>)
2. The PPE Form must be signed by a physician (MD or DO) holding an unlimited license to practice medicine, a nurse practitioner (NP) or a physician assistant (PA) only after the medical history is reviewed, the examination performed, and the PPE Form completed in its entirety. No pre-signed or pre-stamped forms will be accepted.
3. **SIGNATURES**
 - The signature must be hand-written. No signature stamps will be accepted.
 - The signature and license number must be affixed on page two (2).
 - The parent signatures must be affixed to the form on pages one (1) and four (4).
 - The student-athlete signature must be affixed to pages one (1) and four (4).

Your cooperation will help ensure the best medical screening for Indiana's high school athletes.

I PREPARTICIPATION PHYSICAL EVALUATION IHSAA ELIGIBILITY RULES



INDIVIDUAL ELIGIBILITY RULES (Grades 9 through 12)

ATTENTION ATHLETE: Your school is a member of the IHSAA and follows established rules. To be eligible to represent your school in interschool athletics, you:

1. must be a regular bona fide student in good standing in the school you represent; must have enrolled not later than the fifteenth day of the current semester.
2. must have completed 10 separate days of organized practice in said sport under the direct supervision of the high school coaching staff preceding date of participation in interschool contests. (Excluding Girls Golf – See Rule 101)
3. must have received passing grades at the end of their last grading period in school in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take and must be currently enrolled in at least seventy percent (70%) of the maximum number of full credit subjects (or the equivalent) that a student can take. Semester grades take precedence.
 - ... unless you are entering the ninth grade for the first time.
 - ... unless you are transferring from a school district or territory with a corresponding bona fide move on the part of your parents.
 - ... unless you are a ward of a court; you are an orphan, you reside with a parent, your former school closed, your former school is not accredited by the state accrediting agency in the state where the school is located, your transfer was pursuant to school board mandate, you attended in error a wrong school, you transferred from a correctional school, you are emancipated, you are a foreign exchange student under an approved CSIET program. You must have been eligible from the school from which you transferred.
4. must not have reached your twentieth birthday prior to or on the scheduled date of the IHSAA State Finals in a sport.
5. must have been enrolled in your present high school last semester or at a junior high school from which your high school receives its students . . .
 - ... unless you are entering the ninth grade for the first time.
 - ... unless you are transferring from a school district or territory with a corresponding bona fide move on the part of your parents.
 - ... unless you are a ward of a court; you are an orphan, you reside with a parent, your former school closed, your former school is not accredited by the state accrediting agency in the state where the school is located, your transfer was pursuant to school board mandate, you attended in error a wrong school, you transferred from a correctional school, you are emancipated, you are a foreign exchange student under an approved CSIET program. You must have been eligible from the school from which you transferred.
6. must not have been enrolled in more than eight consecutive semesters beginning with grade 9.
7. must be an amateur (have not participated under an assumed name, have not accepted money or merchandise directly or indirectly for athletic participation, have not accepted awards, gifts, or honors from colleges or their alumni, have not signed a professional contract).
8. must have had a physical examination between April 1 and your first practice and filed with your principal your completed Consent and Release Certificate.
9. must not have transferred from one school to another for athletic reasons as a result of undue influence or persuasion by any person or group.
10. must not have received in recognition of your athletic ability, any award not approved by your principal or the IHSAA.
11. must not accept awards in the form of merchandise, meals, cash, etc.
12. must not participate in an athletic contest during the IHSAA authorized contest season for that sport as an individual or on any team other than your school team. (See Rule 15-1a) (Exception for outstanding student-athlete – See Rule 15-1b)
13. must not reflect discredit upon your school nor create a disruptive influence on the discipline, good order, moral or educational environment in your school.
14. students with remaining eligibility must not participate in tryouts or demonstrations of athletic ability in that sport as a prospective post-secondary school student-athlete. Graduates should refer to college rules and regulations before participating.
15. must not participate with a student enrolled below grade 9.
16. must not, while on a grade 9 junior high team, participate with or against a student enrolled in grade 11 or 12.
17. must, if absent five or more days due to illness or injury, present to your principal a written verification from a physician licensed to practice medicine, stating you may participate again. (See Rule 3-11 and 9-14.)
18. must not participate in camps, clinics or schools during the IHSAA authorized contest season. Consult your high school principal for regulations regarding out-of-season and summer.
19. girls shall not be permitted to participate in an IHSAA tournament program for boys where there is an IHSAA tournament program for girls in that sport in which they can qualify as a girls tournament entrant.

This is only a brief summary of the eligibility rules.

You may access the IHSAA Eligibility Rules (By-Laws) at www.ihsaa.org

Please contact your school officials for further information and before participating outside your school.

PREPARTICIPATION PHYSICAL EVALUATION CONSENT & RELEASE CERTIFICATE



I. STUDENT ACKNOWLEDGMENT AND RELEASE CERTIFICATE

- A. I have read the IHSAA Eligibility Rules (*next page or on back*) and know of no reason why I am not eligible to represent my school in athletic competition.
- B. If accepted as a representative, I agree to follow the rules and abide by the decisions of my school and the IHSAA.
- C. I know that athletic participation is a privilege. I know of the risks involved in athletic participation, understand that serious injury, and even death, is possible in such participation, and choose to accept such risks. I voluntarily accept any and all responsibility for my own safety and welfare while participating in athletics, with full understanding of the risks involved, and agree to release and hold harmless my school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agree to take no legal action against my school, the schools involved or the IHSAA because of any accident or mishap involving my athletic participation.
- D. I consent to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me, including but not limited to any claims or disputes involving injury, eligibility or rule violation.
- E. I give the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use my picture or image and any sound recording of me, in all forms and media and in all manners, for any lawful purposes.

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION. (to be signed by student)

Date: _____ Student Signature: (X) _____

Printed: _____

II. PARENT/GUARDIAN/EMANCIPATED STUDENT CONSENT, ACKNOWLEDGMENT AND RELEASE CERTIFICATE

- A. Undersigned, a parent of a student, a guardian of a student or an emancipated student, hereby gives consent for the student to participate in the following interschool sports **not marked out**:
Boys Sports: Baseball, Basketball, Cross Country, Football, Golf, Soccer, Swimming, Tennis, Track, Wrestling.
Girls Sports: Basketball, Cross Country, Golf, Gymnastics, Soccer, Softball, Swimming, Tennis, Track, Volleyball.
- B. Undersigned understands that participation may necessitate an early dismissal from classes.
- C. Undersigned consents to the disclosure, by the student's school, to the IHSAA of all requested, detailed financial (athletic or otherwise), scholastic and attendance records of such school concerning the student.
- D. Undersigned knows of and acknowledges that the student knows of the risks involved in athletic participation, understands that serious injury, and even death, is possible in such participation and chooses to accept any and all responsibility for the student's safety and welfare while participating in athletics. With full understanding of the risks involved, undersigned releases and holds harmless the student's school, the schools involved and the IHSAA of and from any and all responsibility and liability, including any from their own negligence, for any injury or claim resulting from such athletic participation and agrees to take no legal action against the IHSAA or the schools involved because of any accident or mishap involving the student's athletic participation.
- E. Undersigned consents to the exclusive jurisdiction and venue of courts in Marion County, Indiana for all claims and disputes between and among the IHSAA and me or the student, including but not limited to any claims or disputes involving injury, eligibility, or rule violation.
- F. Undersigned gives the IHSAA and its assigns, licensees and legal representatives the irrevocable right to use any picture or image or sound recording of the student in all forms and media and in all manners, for any lawful purposes.
- G. Please check the **appropriate space**:
- | | |
|--|---|
| <input type="checkbox"/> The student has school student accident insurance. | <input type="checkbox"/> The student has football insurance through school. |
| <input type="checkbox"/> The student has adequate family insurance coverage. | <input type="checkbox"/> The student does not have insurance. |

Company: _____ Policy Number: _____

I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE PROVISION.

(to be completed and signed by all parents/guardians, emancipated students; where divorce or separation, parent with legal custody must sign)

Date: _____ Parent/Guardian/Emancipated Student Signature: (X) _____

Printed: _____

Date: _____ Parent/Guardian Signature: (X) _____

Printed: _____

CONSENT & RELEASE CERTIFICATE

Indiana High School Athletic Association, Inc.
9150 North Meridian St., P.O. Box 40650
Indianapolis, IN 46240-0650

File In Office of the Principal
Separate Form Required for Each School Year

Athlete's Name: _____ DOB _____

Consent for Treatment. I, the athlete, or my representative, wishes to participate in the Reid Sport Medicine High School Athletic Physicals program. I understand that some of the individuals that are providing all or a portion of the examination may not be employees or agents of Reid Hospital and Health Care Services (Reid Hospital), Reid Rehabilitation Services (Reid Rehab) or Reid Physician Associates (RPA). I authorize the participating allied health personnel and physician, regardless of their employment status with Reid Hospital, Reid Rehab or RPA to render a pre-participation athletic physical examination on me. I understand that Reid Hospital, Reid Rehab and RPA are not responsible for those individuals who are not their employee. I understand that the practice of medicine is not an exact science and acknowledge that no guarantee has been made to me as to the result of this examination. I understand that it is my right to consent or to refuse consent for this examination. I understand that the information and forms for this examination will be forwarded to the athlete's school system and maintained in part by Reid Hospital. I understand that Reid Hospital, Reid Rehab and RPA will not be responsible for any valuables brought to any Reid Hospital, Reid Rehab or RPA facility by me.

I have read or had the opportunity to read the Consent for Treatment or it has been fully explained to me, and I am satisfied that I understand its content and significance. My consent is given freely, voluntarily and without reservation.

Patient or Responsible Person's signature

Date/Time

(if 18 years or older and appropriate)

Reid Hospital & Health Care Services
Richmond, IN 47374 (765) 983-3000
**General Consent for Pre-participation
Athletic Physical Examination**



Reid Sports Medicine

REID HEALTH CONSENT FOR TREATMENT, HEALTH CARE OPERATIONS AND AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR THE SCHOOL YEAR 2019-20.

I _____ (print or type name) consent to the provision of care.
(Athlete's Name)

- I understand that this care may include medical treatment, special tests, exams, evaluation, treatment and rehabilitation of an injury, illness or disability that may impact my ability to participate in athletics. I acknowledge that no guarantees have been given to me as to the outcome of any examination or treatment and all results of any examination and/or treatment are kept confidential.
- I understand and agree that others may assist or participate in providing care. This may include, but may not be limited to team physicians, athletic trainers, family physicians, school nurses and emergency medical personnel. As such, I understand that there will be open communication/access to the medical record, verbally, electronically, or in print, including but not limited to diagnosis, severity, playing status, plan of care, restrictions and limitations among the medical providers involved in my care. Under the direction of a certified athletic trainer, student athletic trainers may also provide care.
- I authorize Reid Health to provide information related to my care to my family/school/team physician, school nurse, coaches, athletic department personnel, school principals, EMS personnel, and such persons as needed for them to provide consultation, treatment, establish a plan of care and determine eligibility.
- I understand that release of my health record(s) will only be for the purpose stated on this form.
- I understand that the health record(s) released by Reid Health may possibly be re-disclosed by the facility/person that receives the record(s) and therefore (1) Reid Health and its staff/employees have no responsibility or liability as a result of the re-disclosure and (2) such information would no longer be protected by the Privacy Rule.
- I understand that the Athletic Trainer may contact me via cell phone or text, but will not communicate confidential medical information via text.
- I understand that this Authorization is in effect from the date of the signature extending until July 31st of the year listed as school year above.
- I understand that I have the right to revoke this Authorization form at any time by sending a written request to Reid Hospital's Sports Health Manager. I understand that the revocation does not apply to any release of my health record(s) that may have taken place prior to the date the request to revoke the Authorization is received.
- I understand that the Notice of Privacy Practices document is posted in the Athletic Training Room at my school. I also understand that a copy of this Notice is available to me upon my request or by visiting the hospital's website at www.reidhealth.org

I agree to the release of information to the phone numbers, accounts and individuals listed as contacts in the Reid Sports Medicine Athlete Demographic form, but not limited to, injury occurrence, medical status, playing status and treatment plan by the following means:

Athlete's Signature

Date / Time

**Parent or Guardian Signature

Date / Time

**Parent or Guardian signature not necessary for College Students over the age of eighteen (18). Parent or Guardian signature is necessary for all high school students and all minors under eighteen (18) years of age and not an emancipated minor or otherwise not competent to give consent.

REID SPORTS MEDICINE ATHLETE DEMOGRAPHICS FORM

(Please Print Clearly)

Legal Name First _____ Middle Initial _____ Last _____

Nickname _____ Gender M F DOB _____ Year in school 5 6 7 8 Fr So Jr Sr 5th Year

Primary Address _____ City _____ State _____ Zip _____

Home Phone (leave blank if no home phone) _____

Parent's Cell # () _____ Student's Cell # () _____

Secondary Address _____ City _____ State _____ Zip _____

Sport 1 _____ Sport 2 _____ Sport 3 _____ Sport 4 _____

By listing a person as a contact you authorize the release of medical information to that individual. List in the order you would prefer to be contacted. Check box to authorize us to leave medical information on voice mail at this phone number.

Contact name	Relation	Home Phone	Cell Phone	Work Phone	E-Mail
1		<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	
2		<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	
3		<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	
4		<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	<input type="checkbox"/> () ()	

Other individuals that are authorized to receive medical information _____

Specific individuals that are not authorized to receive medical information (i.e. estranged family members) _____

Medical and Environmental Allergies _____

Important medical alerts _____

Regular medications _____

Primary Insurance provider _____ Policy # _____ Group # _____ Policy Holder _____

Secondary Insurance provider _____ Policy # _____ Group # _____ Policy Holder _____

Primary Physician _____ Primary Dentist _____ Preferred Hospital Emergency Dept. _____