Santa Clara Swim Club Medical release forms:
PLEASE PRINT USING AN INK PEN

SCSC Health Evaluation Forms and HIPAA Release
PLEASE PRINT

_____ | _____ | _____
Last **First** **M. I.**

Preferred name _____ **Date of Birth** ____ | ____ | ____
M **D** **Y**

Sex: **M** **F**

Address _____ **Apt.** _____

City _____ **Zip Code** _____

Parents/guardian phone _____ **Work** _____ **Cell** _____

Primary/family physician _____ **Phone** _____

Emergency Contact _____ **Relation** _____

Phone _____ **Work Phone** _____ **Cell** _____

Parents' Permission/HIPAA Release/Acknowledgement of Risk for Athletic Participation

As the parents or legal guardian of the above named student-athlete, I give my consent for his/her participation in SCSC's training program and athletic events and the physical evaluation for that participation. I understand that this is simply a screening evaluation and not a substitute for regular health care. I also grant permission for treatment deemed necessary for a condition arising during participation of these events, including medical or surgical treatment that is recommended by a medical doctor. I grant permission to nurses, trainers, and coaches as well as physicians or those under their direction who are part of athletic injury prevention and treatment, to have access to necessary medical information/records/documentation. I know that the risk of injury to my child/ward comes with participation in sports and during travel to and from play, meets and practice. I have had the opportunity to understand the risk of injury during participation in sports through meetings, written information, or by some other means. My signature below indicates that to the best of my knowledge, my answers to the above questions are complete and correct. I understand that the data acquired during these evaluations may be used for research purposes.

I give consent for the head athletic trainer at SCSC to **release** such information regarding my child's medical history and/or records that pertain directly to athletic participation at SCSC. This information may be requested by agents of any amateur or professional athletic organization, college or university, or insurance company. I also grant permission for the SCSC athletic trainer to **receive** medical information from any medical practice concerning my child's athletic injury information for the continuity of care. This information may be transmitted via telephone, personal interview, electronic mail, postal service, fax or other form of media not listed here. **This permission will be in effect from June 1,2011-June 31,2013**

PRINT Name, Parent/Legal Guardian _____

Parent/Legal Guardian Signature _____ Date _____

Yes No Do you have health insurance? If yes, see below.

Yes No Do you have Medicaid? If yes, Medicaid number: _____

Yes No Does your insurance require you to get a referral from your family physician prior to seeing a specialist (orthopaedist, neurologist, general surgeon, etc.)

Name of insurance company _____

Mailing address _____
Street/PO Box City State Zip

Insured's name _____

Policy number _____ Group number _____

Consent for Emergency Medical Treatment

As a parent/guardian of the student named in this document, I/we hereby grant permission and consent to the SCSC Head Athletic Trainer, and Coaching Staff for the following:

1. Provision of treatment for athletic injuries
2. Provision of appropriate medical/emergency attention that may be deemed necessary
3. To act on my behalf in the case of a medical emergency requiring transport to and treatment at a hospital or other medical/urgent care facility
4. To the physician and/or appropriate medical personnel to attend to my child
5. To the physician, coaches, administration, and athletic trainer for the release of medical information pertaining to the treatment and rehabilitation of my child's injury(s) via fax, email, paper, telephone, and/or computer
6. Provide the following to be given to my child in the event of sudden illness/injury and for the immediate relief of pain/illness:

Pepto-Bismol or similar antispasmodic	Yes	No
Advil or Motrin	Yes	No
Tylenol	Yes	No
Tums or similar antacids	Yes	No
BenadrylCough drops		

Parent/guardian signature _____ Date _____