

STUDENT ATHLETE INFORMATION AND INSURANCE FORM

Student First Name: _____ Middle: _____ Last: _____

2026-27 school year grade: _____ Student ID#: _____ Date of Birth: _____

Parent/Guardian Name: _____ Parents email: _____

Parent/Guardian Phone: _____ Work phone: _____

Secondary Parent/Guardian Name: _____ Secondary email: _____

Secondary Parent/Guardian Phone: _____ Secondary Work phone: _____

Address: _____

Please list a contact OTHER than primary parent/guardian to contact in the event of emergency if primary parent/guardian can not be reached.

Name of emergency contact: _____

Relationship: _____ Phone: _____

The following information is very important to have on file in case of any emergency situation. Please fill in the info Marion to the best of your ability. List an insurance coverage that is current for your student, including Champus, Medicare, Medicaid, accident policies, HMO's, etc. If your student is not currently covered under an insurance policy please check the "No insurance" box below.

What type of policy is your student covered under? Group Individual No insurance

Is your student covered under a CHIPS or Medicaid policy? Yes No

If you marked group, individual, or yes to the Medicaid coverage please fill out the remainder info.

Name of Insured: _____ Relationship to student: _____

Insurance company name: _____ Policy #: _____

Insurance phone number: _____ PCP office/clinic name: _____

STUDENT ATHLETE CONSENT FOR TREATMENT AND CARE

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

Additionally, I give my permission and consent for the evaluation and treatment of my child by the physicians at the CHRISTUS Health System, including CHRISTUS Saturday Sports Injury Clinic.

I hereby consent to and permit CHRISTUS Trinity Clinic Physicians/Staff (and/or their designee) to provide evaluation, medical treatment (including emergent or urgent treatment if necessary) to me/my child, including hospitalization and physician follow-up according to their medical judgment at the CHRISTUS Health System and/or its Saturday Morning Sports Injury Clinic.

I further authorize CHRISTUS Health System to obtain and release personal medical/insurance data about me for treatment payment or operations related to my injury, illness, physical examination(s) in accordance with the applicable state and federal privacy laws.

I am of sound mind and competent to sign this form.

I have read this form, understand it and agree to the terms and conditions.

Parent/Legal Guardian signature

Date

Student/Athlete (if 18 years of age or older)

Date

STUDENT ATHLETE PRIVACY FORM
Authorization for
Disclosure of Protected Health Information

I, _____, parent or guardian of _____ (the “student athlete”), hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel represent CHRISTUS Orthopedic & Sports Medicine Institute to release information regarding the student athlete’s protected health information and related information regarding any injury or illness during the student athlete’s training for and participation in athletics at _____ School (the “School”). This protected health information may concern the student athlete’s medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related individually identifiable health information. This protected health information may be released to other health care providers, hospitals and/or medical clinics, Saturday Morning Clinics, and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, and officials of _____ College and the _____ School District.

I understand that as a parent/legal guardian my authorization/consent to the disclosure of the student athlete’s protected health information is a condition for the student athlete’s participation in interscholastic sports at the School. I understand that the student athlete’s protected health information is protected under federal law. I, the parent/legal guardian, understand that once information is disclosed per this authorization, the information is subject to re-disclosure by the recipient and may no longer be protected under federal law. I may revoke this authorization at any time by notifying the School’s athletic director in writing, but if I do, it will not have any effect on actions taken in reliance of my prior authorization. This authorization expires one year from the date it is signed.

REQUIRED SIGNATURE FOR PARTICIPATION FOR INTERSCHOLASTIC SPORTS

Print Student Athlete Name

Signature of Parent/Legal Guardian

Date

NOTICE OF PRIVACY PRACTICES

By signing above I acknowledge that I have received or have been offered a copy of CHRISTUS Orthopedic & Sports Medicine Institute’s Notice of Privacy Practices.

PREPARTICIPATION PHYSICAL EVALUATION -- MEDICAL HISTORY

This **MEDICAL HISTORY FORM** must be completed **annually** by parent (or guardian) and student in order for the student to participate in activities. These questions are designed to determine if the student has developed any condition which would make it hazardous to participate in an event.

Student's Name: (print) _____ Sex _____ Age _____ Date of Birth _____
 Address _____ Phone _____
 Grade _____ School _____
 Personal Physician _____ Phone _____

In case of emergency, contact:

Name _____ Relationship _____ Phone (H) _____ (W) _____

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

<p>1. Have you had a medical illness or injury since your last check up or physical? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Have you been hospitalized overnight in the past year? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had surgery? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. Have you ever had prior testing for the heart ordered by a physician? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever passed out during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had chest pain during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you get tired more quickly than your friends do during exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had racing of your heart or skipped heartbeats? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had high blood pressure or high cholesterol? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been told you have a heart murmur? <input type="checkbox"/> Yes <input type="checkbox"/> No Has any family member or relative died of heart problems or of sudden unexplained death before age 50? <input type="checkbox"/> Yes <input type="checkbox"/> No Has any family member been diagnosed with enlarged heart, (dilated cardiomyopathy), hypertrophic cardiomyopathy, long QT syndrome or other ion channelopathy (Brugada syndrome, etc), Marfan's syndrome, or abnormal heart rhythm? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had a severe viral infection (for example, myocarditis or mononucleosis) within the last month? <input type="checkbox"/> Yes <input type="checkbox"/> No Has a physician ever denied or restricted your participation in activities for any heart problems? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Have you ever had a head injury or concussion? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever been knocked out, become unconscious, or lost your memory? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many times? _____ When was your last concussion? _____ How severe was each one? (Explain below) _____ Have you ever had a seizure? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have frequent or severe headaches? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had numbness or tingling in your arms, hands, legs or feet? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you ever had a stinger, burner, or pinched nerve? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Are you missing any paired organs? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. Are you under a doctor's care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you currently taking any prescription or non-prescription (over-the-counter) medication or pills or using an inhaler? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Do you have any allergies (for example, to pollen, medicine, food, or stinging insects)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Have you ever been dizzy during or after exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Do you have any current skin problems (for example, itching, rashes, acne, warts, fungus, or blisters)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Have you ever become ill from exercising in the heat? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>12. Have you had any problems with your eyes or vision? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>13. Have you ever gotten unexpectedly short of breath with exercise? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have asthma? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you have seasonal allergies that require medical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>14. Do you use any special protective or corrective equipment or devices that aren't usually used for your activity or position (for example, knee brace, special neck roll, foot orthotics, retainer on your teeth, hearing aid)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>15. Have you ever had a sprain, strain, or swelling after injury? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you broken or fractured any bones or dislocated any joints? <input type="checkbox"/> Yes <input type="checkbox"/> No Have you had any other problems with pain or swelling in muscles, tendons, bones, or joints? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, check appropriate box and explain below:</p> <table border="0" style="width:100%;"> <tr> <td><input type="checkbox"/> Head</td> <td><input type="checkbox"/> Elbow</td> <td><input type="checkbox"/> Hip</td> </tr> <tr> <td><input type="checkbox"/> Neck</td> <td><input type="checkbox"/> Forearm</td> <td><input type="checkbox"/> Thigh</td> </tr> <tr> <td><input type="checkbox"/> Back</td> <td><input type="checkbox"/> Wrist</td> <td><input type="checkbox"/> Knee</td> </tr> <tr> <td><input type="checkbox"/> Chest</td> <td><input type="checkbox"/> Hand</td> <td><input type="checkbox"/> Shin/Calf</td> </tr> <tr> <td><input type="checkbox"/> Shoulder</td> <td><input type="checkbox"/> Finger</td> <td><input type="checkbox"/> Ankle</td> </tr> <tr> <td><input type="checkbox"/> Upper Arm</td> <td><input type="checkbox"/> Foot</td> <td></td> </tr> </table> <p>16. Do you want to weigh more or less than you do now? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>17. Do you feel stressed out? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>18. Have you ever been diagnosed with or treated for sickle cell trait or sickle cell disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><i>Females Only</i> <input type="checkbox"/> I choose not to provide written information on Question 19 but will discuss with a medical professional:</p> <p>19. When was your first menstrual period? _____ When was your most recent menstrual period? _____ How much time do you usually have from the start of one period to the start of another? _____ How many periods have you had in the last year? _____ What was the longest time between periods in the last year? _____</p> <p><i>Males Only</i> <input type="checkbox"/> I choose not to provide written information on Question 20 but will discuss with a medical professional:</p> <p>20. Are you missing a testicle? _____ Do you have any testicular swelling or masses? _____</p> <p><input type="checkbox"/> OPTIONAL: An electrocardiogram (ECG) is not required. By marking this box, I choose to obtain an ECG for my student. I understand it is the responsibility of my family to schedule and pay for such an ECG. I have read and understood the information about cardiac screening on the UIL Sudden Cardiac Arrest Awareness Form.</p> <p>EXPLAIN 'YES' ANSWERS IN THE BOX BELOW (attach another sheet if necessary):</p> <div style="border: 1px solid black; height: 100px; width: 100%;"></div>	<input type="checkbox"/> Head	<input type="checkbox"/> Elbow	<input type="checkbox"/> Hip	<input type="checkbox"/> Neck	<input type="checkbox"/> Forearm	<input type="checkbox"/> Thigh	<input type="checkbox"/> Back	<input type="checkbox"/> Wrist	<input type="checkbox"/> Knee	<input type="checkbox"/> Chest	<input type="checkbox"/> Hand	<input type="checkbox"/> Shin/Calf	<input type="checkbox"/> Shoulder	<input type="checkbox"/> Finger	<input type="checkbox"/> Ankle	<input type="checkbox"/> Upper Arm	<input type="checkbox"/> Foot	
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It is understood that even though protective equipment is worn by athletes, whenever needed, the possibility of an accident still remains. Neither the University Interscholastic League nor the school assumes any responsibility in case an accident occurs.

If, in the judgment of any representative of the school, the above student should need immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse or school representative. I do hereby agree to indemnify and save harmless the school and any school or hospital representative from any claim by any person on account of such care and treatment of said student.

If, between this date and the beginning of participation, any illness or injury should occur that may limit this student's participation, I agree to notify the school authorities of such illness or injury.

I hereby state that, to the best of my knowledge, my answers to the above questions are complete and correct. Failure to provide truthful responses could subject the student in question to penalties determined by the UIL

Student Signature: _____ Parent/Guardian Signature: _____ Date: _____

Any Yes answer to questions 1, 2, 3, 4, 5, or 6 requires further medical evaluation which may include a physical examination. Written clearance from a physician, physician assistant, chiropractor, or nurse practitioner is required before any participation in UIL practices, games or matches. **THIS FORM MUST BE ON FILE PRIOR TO PARTICIPATION IN ANY PRACTICE, SCRIMMAGE, PERFORMANCE OR CONTEST BEFORE, DURING OR AFTER SCHOOL.**

For School Use Only:

This Medical History Form was reviewed by: Printed Name _____ Date _____ Signature _____