MPS-Department of Academic Excellence
OFFICE OF INTERSCHOLASTIC ATHLETICS

PHYSICAL EXAMINATION CARD-APPROVAL FOR TWO YEARS OF COMPETITION

20___ - 20___ & 20 ___ - 20 ___ SCHOOL YEARS

1. Examination taken after April 1st is good for the following TWO SCHOOL YEARS.
2. Examination taken before April 1st is good for the remainder of that SCHOOL YEAR and the following SCHOOL YEAR.

NAME: _____ DATE OF BIRTH: _____ SEX: _____

The above-named student has been examined and there are no apparent contraindications to participating in interscholastic athletic activities except as follows:

Sports or school activities in which this student **CANNOT** participate are: _____

_____

If student is restricted or disqualified, please indicate reason(s): _____

_____

_____
Signature of Licensed Physician, Advanced Practice Nurse Prescriber or Physician's Assistant

Address: _____Telephone: _____ Exam Date: _____

ALL STUDENT PARTICIPATING IN INTERSCHOLASTIC ATHLETICS MUST HAVE THIS CARD ON FILE AT THEIR SCHOOL PRIOR TO PRACTICE OR PARTICIPATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

School Name: _____ High School

Pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 and the regulations promulgated hereunder (collectively known as "HIPAA"), I authorize health care providers of **ATHLETE NAME**:_____, **DATE OF BIRTH**: _____, to disclose medical information regarding the injury and treatment of named individual to the following representatives of MPS High School: Athletic Director, Athletic Trainer, Team Physician, and Team Coach for the purposes of treatment, emergency care and injury record-keeping.

Medical Information, in this context, pertains only to patient health care records regarding a specific injury and the treatment thereof. The request for medical information includes all patient health care records regarding the care, evaluation, referral or treatment including, but not limited to, any and all records, reports, correspondence, radiographic films pertaining to the care and treatment of an injury sustained by the above-named student-athlete on _____. **(SCHOOL TO INSERT DATE OF INJURY.)** This includes all portions of my medical records which my physicians, or other health care providers, or I have specifically designated as "confidential."

I understand that my signed authorization will be kept in a locked cabinet along with all medical information received and that said information will be available only to the individuals named above.

Treatment, payment, enrollment or eligibility of benefits may not be conditioned on obtaining patient's authorization.

The purpose of disclosure of medical records is to facilitate treatment of injured student-athletes. I understand that the information obtained by the use of this authorization may be subject to re-disclosure and the information obtained is therefore no longer protected by HIPAA.

This consent is revocable by the patient at any time except to the extent that the provider listed above has taken action upon it. A revocation is effective by the Health Care Provider listed above upon receipt of a written request to revoke, and a copy of the executed authorization form. A photocopy of this authorization shall be considered as valid as the original. This authorization shall remain in effect for one year from date of signing.

This authorization specifically authorizes the health care provider named above to disclose records created at any time after the signing, regarding the specific injury, until the authorization expires one year from the date of signing.

_____ _____ _____

Athlete's (Patient) Signature Date Signed Witness Signature (Optional)

_____ _____

Parent/Guardian's Signature Date Signed