Cleared to Compete Pre-Registration

Student Name: _____

Student Date of Birth: _____

Name of School for 2023-24 School Year: _____

Email* Address: _____

(*Email is required if you do not attend Burke County Public Schools)

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Cleared to Compete | Medical Release

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RELEASE & MEDICAL AUTHORIZATION

In consideration of your school system allowing _____ (Student-Athlete Name) to participate in athletics, I, the parent or guardian of the student-athlete, agree to release and hold Burke County School System, its athletic coaches, and other employees free, harmless, and indemnified from and against any and all claims, suits, or causes of action arising from or out of an injury that the student-athlete may suffer from participation in athletics other than an injury from gross or willful negligence. If the student-athlete is injured while participating in athletics and your school system is unable to contact the parent/guardian, I, the parent or guardian of the student-athlete, grant permission for necessary medical treatment for a condition arising during participation in these events, including medical or surgical treatment recommended by a physician and accept the financial responsibility for such medical care and treatment.

ASSUMPTION OF RISK

I, the parent or guardian of the student-athlete, acknowledge and understand the risk of injury involved in athletic participation. I, the parent or guardian of the student-athlete, understand that the student-athlete will be under the supervision and instructions of the coach in order to reduce the risk of injury to the student and other athletes. However, I, the parent or guardian of the student-athlete, acknowledge and understand that neither the coach nor your school system can eliminate the risk of injury in sports. Injuries may and do occur. Sports injuries can be severe and, in some cases, may result in permanent disability or even death. I, the parent or guardian of the student-athlete, freely, knowingly, and willfully accept and assume the risk of injury that might occur from participation in athletics.

HIPAA / FERPA RELEASE

The above-named student-athlete has opted his/her rights under the US Department of Health and Human Resources guidelines. By signing this release, the student-athlete allows sharing of medical information between the Sports Medicine Staff (team physicians and medical staff, athletic trainers, and student assistants), the school athletics staff (Athletic Director and Coaches), school administration and his/her medical provider(s). In an emergency, information may be shared with emergency medical personnel. Every reasonable effort will be made to protect this information. It is understood that once this medical information is disclosed, it is no longer protected under the HIPAA/FERPA guidelines.

I understand that providers who participate in Cleared to Compete, including Blue Ridge HealthCare Hospitals, Inc., ("Blue Ridge"), may use the data acquired during the evaluation for their internal healthcare operation purposes, such as to evaluate the quality of the services provided or how the services were used. I understand that the providers may be interested in learning more about heart conditions and how they are detected. I would be willing to answer a brief questionnaire about my thoughts on detecting a heart condition while on-site at the Cleared to Compete event. I understand this is voluntary and that I am not required to participate in the questionnaire to participate in the Cleared to Compete screenings.

I understand that if I/my child is found to have a heart abnormality during the screening or during follow-up care, I/my child may qualify for certain cardiac research studies and/or focus groups. I would be willing to be contacted to consider discussing my experience as part of a research study and/or focus group. I understand this is voluntary and that I am not required to agree to be contacted about, or to join in, any studies or focus groups to participate in the Cleared to Compete screenings.

Cleared to Compete

Cleared to Compete is a program sponsored by Blue Ridge to provide medical screenings to students interested in participating in school sports. The information learned through these medical screenings will be shared with your school system to determine eligibility to participate in school sports. Before a student can participate in the medical screenings, the student's parent, guardian, or authorized representative (or the student, if 18 or older) must authorize Clear to Compete (which includes Blue Ridge and the other health care providers) to provide the screenings and release the results to your school system. Please read each of the following links carefully, and if you agree, type your name and the date on the bottom of each form and click I Agree. The student will only receive the screenings if all required forms are correctly completed and signed. Only students over 18 can sign the forms; otherwise, the parent or guardian of the student must sign the forms. If it is later discovered that a student under 18 improperly signed these forms, the student will not be allowed to participate in Clear to Compete.

Cleared to Compete

By signing this document, you are requesting your child to receive the Cleared to Compete medical screenings, including a sports-specific medical screening, heart screenings, musculoskeletal screenings, and a vision examination, as well as a review of the student's medical history. There are minimal risks associated with the screenings. The benefits are that the student will learn valuable medical information that can be used to complete the student-athlete eligibility forms for the schools. The student is not obligated to have these screenings and may choose not to do so. These screenings are being done for the purpose of gathering information and will not involve medical treatment; if an emergency arises during the screenings, however, medical personnel will respond. These medical screenings will be provided by healthcare providers who are on the hospital's medical staff. If a medical condition is discovered during the screenings that require further medical attention, the information learned during the screenings may be shared with the

healthcare providers who provide such follow-up care, as permitted under law. The medical personnel participating in Cleared to Compete may access other information about the student stored by Blue Ridge as necessary to provide the screenings. By signing below, I understand and agree to the above, and request that the student participates in Cleared to Compete. I also agree to release the healthcare providers participating in Cleared to Compete from any liability, claims, suits, or damages relating to or arising from the student's participation in the Cleared to Compete medical screening program and/or participation in a school sport based on the screening results.

We are required to make available to you the Notice of Privacy Practices that apply to Cleared to Compete. This can be found at www.unchealthblueridge.org/privacy.

I acknowledge that the Blue Ridge Notice of Privacy Practices has been made available to me, and I agree that I can receive it electronically. I understand I have the right to receive a paper copy of the Notice of Privacy Practices upon request.

I authorize the health care providers participating in Cleared to Compete, including Blue Ridge, to provide the information gathered

about _____ (Student-Athlete Name) through the Cleared to Compete medical screenings to the students family, school, school athletic team, personal physician, school nurse, coaches, and athletic directors, and as otherwise directed by the student/parent/guardian. This includes filling out any forms that are presented for completion, such as any sports participation screening forms for the school system. The information is being disclosed for the purpose of providing information about the student that may be necessary to determine eligibility for sports. This Authorization will expire one(1) year from the date below. Please note the following:

Generally, a healthcare provider may not condition treatment, payment, enrollment, or eligibility for benefits on whether the individual signs the Authorization. In this situation, however, the Cleared to Compete medical screenings are being done for the sole purpose of sharing the information with your school system and their athletic departments for sports eligibility. Therefore, this Authorization must be signed before the medical screenings can be conducted.

You have the right to revoke this Authorization at any time by sending a written request to the Blue Ridge Chief Privacy Officer, Thomas Eure, at 2201 S. Sterling Street, Morganton, NC 28655. Note that revocation of the Authorization does not apply to any information that was properly released under this Authorization before we received your request to revoke it.

Information used or disclosed based on this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by this Authorization or federal or state privacy laws. You are entitled to a copy of the Authorization.

I authorize the healthcare providers of Cleared to Compete, including Blue Ridge, to include * (Student Name) in photographs and videos related to the program for internal and external audiences for purposes of documenting the event, reporting on the event, or advertising future events for Cleared to Compete. I also authorize Cleared to Compete to allow third-party media outlets, such as news stations or newspapers, to take pictures, videos, or interviews of the student for their same use. In addition to their likeness, I understand that the name, age, grade, sport, school, and other similar information about the student may be included in the released information. Pictures or videos of the student undergoing the medical screenings may also be taken and published. The medical information learned during the screenings will not be disclosed by Cleared to Compete under this Authorization. I understand that Blue Ridge and the other healthcare providers in Cleared to Compete do not control third-party media sources or what they do with the information they obtain. This Authorization will expire when the pictures, videos, or materials are no longer in use.

Please note the following:

- Participation in Cleared to Complete is not conditioned on signing this Authorization. The student can still receive the medical screenings under the program even if this Authorization is not signed.
- You have the right to revoke this Authorization at any time by sending a written request to the Blue Ridge Chief Privacy Officer, Thomas Eure, at 2201 S. Sterling Street, Morganton, NC 28655. Note that revocation of the Authorization does not apply to any information that was properly released under this Authorization before we received your request to revoke it.
- Information used or disclosed based on this Authorization may be subject to re-disclosure by the recipient and will no longer be protected by this Authorization or the privacy laws.
- You are entitled to a copy of the Authorization.

_____ _____

Parent/Guardian Print Name Date

_____

Parent/Guardian Signature

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Authorization for Education, Fundraising and Marketing / Public Relations Purposes - Photo, Video and Other Protected Health Information (PHI)

Patient's Name (print)				*Date of Birth*
Patient's Address	*City*	*State*	*Zip*	*Phone #*

I AUTHORIZE THE RELEASE OF MY PHI FROM:

Name of UNC Health Blue Ridge Hospital affiliate that may release my PHI:

I AUTHORIZE THE RELEASE OF MY PHI TO:

(*check the purpose for the release, then describe the intended use of PHI and print name of the entity and/or individual that will receive PHI with contact information listed for the entity and/or individual.***)**

☑ **Marketing Public/Relations**: If the purpose of the release is for Marketing/Public Relations

Describe *marketing/public relations activities*:

Cleared to Compete Athletic Event

Print name and contact information of individual or department performing marketing services:

Sports Medicine Department

☐ **Fundraising**: If the purpose of the release is for fundraising:

Describe fundraising activities: _____

Print name and contact information of entity performing the fundraising activity:

☐ **Education**: If Release is for educational purposes**:**

My PHI may be used for education offered or directed by my UNC Health Blue Ridge physician or provider in any format or forum which may include but not be limited to publication in written or online media, books or journals, classroom instruction and/or medical training at UNC Health Blue Ridge or other educational institutions, and/or at local national and global conferences or other professional or educational events.

Print name and contact information of physician and/or department that will receive PHI:

IF RELEASE IS FOR EDUCATIONAL PURPOSES, A COPY MUST BE PLACED IN THE PATIENT'S CHART.

INFORMATION THAT CAN BE RELEASED: If specific dates only, list dates: June 3, 2023

☐ Name ☐ Address ☐ **Video and/or photograph(s) of me which may include my face and images or video of procedures or treatment I have received**	☐ Testimonials ☐ Diagnosis ☐ Treatment Information ☐ Prognosis ☐ Physician or care giver's name(s)	☐ Name of facility, hospital or clinic where treatment was received ☐ Other (describe in detail): _____ _____ _____ _____ _____	**I further authorize the release of the following information which may be included in my PHI:** ☐ Mental Health/Psychiatric Treatment ☐Alcohol or Substance Abuse Treatment ☐ STD/HIV/AIDS Treatment(s) or Test(s) ☐ Genetic Testing

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Authorization for Education, Fundraising and Marketing / Public Relations Purposes - Photo, Video and Other Protected Health Information (PHI)

I will not receive remuneration for releasing my PHI for the purpose(s) listed above.
I hereby release UNC Health Blue Ridge, and any agents, officers, directors, and employees from any and all liability that may arise from the release of my PHI, as authorized by this form.
I have the right to revoke this Authorization at any time if I do so in writing and address it to the person or institution named above. The revocation will not apply to any information already released as a result of this Authorization.
I may refuse to sign this Authorization, and I cannot be denied or refused treatment if I refuse to sign and my refusal to sign this Authorization will not affect my treatment, payment, enrollment or eligibility for benefits or the quality of care I receive.
Once information is disclosed pursuant to this Authorization, it is possible that it will no longer be protected by the federal medical privacy laws and could be re-disclosed by the person or agency that receives it.
This Authorization shall not have an expiration date and shall remain in effect unless and until I provide my written revocation made to the UNC Health Blue Ridge, to the attention of Marketing Department, UNC Health Blue Ridge 2201 South Sterling Street, Morganton, NC 28655

My signature below indicates that I am giving permission for the use and disclosure of the PHI described above.

Signature of Patient	*Date*	*Time*
OR Signature of Authorized Representative	*Date*	*Time*
Printed Name of Authorized Representative	*Phone Number of Authorized Representative*	
Explain Representative's authority to act on behalf of the Patient:		

■ PREPARTICIPATION PHYSICAL EVALUATION

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex: M/F _____

List past and current medical conditions. _____

_____

Have you ever had surgery? If yes, list all past surgical procedures. _____

_____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

_____

_____

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

_____

_____

Patient Health Questionnaire Version 4 (PHQ-4)

*Over the last 2 weeks, how often have you been bothered by any of the following problems? (**check box next to appropriate number**)*

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	☐ 0	☐ 1	☐ 2	☐ 3
Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3
Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?	☐	☐
2. Has a provider ever denied or restricted your participation in sports for any reason?	☐	☐
3. Do you have any ongoing medical issues or recent illness?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?	☐	☐
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?	☐	☐
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?	☐	☐
7. Has a doctor ever told you that you have any heart problems?	☐	☐
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.	☐	☐

HEART HEALTH QUESTIONS ABOUT YOU (*CONTINUED*)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?	☐	☐
10. Have you ever had a seizure?	☐	☐
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?	☐	☐
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?	☐	☐
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?	☐	☐

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?	☐	☐
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?	☐	☐
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?	☐	☐
17. Are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?	☐	☐
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?	☐	☐
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?	☐	☐
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?	☐	☐
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?	☐	☐
22. Have you ever become ill while exercising in the heat?	☐	☐
23. Do you or does someone in your family have sickle cell trait or disease?	☐	☐
24. Have you ever had or do you have any problems with your eyes or vision?	☐	☐

MEDICAL QUESTIONS (*CONTINUED*)	Yes	No
25. Do you worry about your weight?	☐	☐
26. Are you trying to or has anyone recommended that you gain or lose weight?	☐	☐
27. Are you on a special diet or do you avoid certain types of foods or food groups?	☐	☐
28. Have you ever had an eating disorder?	☐	☐
FEMALES ONLY	**Yes**	**No**
29. Have you ever had a menstrual period?	☐	☐
30. How old were you when you had your first menstrual period?		
31. When was your most recent menstrual period?		
32. How many periods have you had in the past 12 months?		

Explain "Yes" answers here.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____