NAME	SPORT	GTID#:

I verify that I have read, understand and will comply with the Georgia Tech Sports Medicine Medical Eligibility and Treatment Statement listed below.

Signature _____ Date _____

Georgia Tech Sports Medicine
Injury, Illness and Medical Procedures

Intercollegiate Athletic Medical Eligibility

- All physical examinations are scheduled through the athletic training staff after preliminary academic eligibility has been confirmed through the athletic administration.
- All prospective student-athletes must complete and pass a physical examination administered by a Georgia Tech team physician or designee before he/she is permitted to participate in athletic activity for Georgia Tech. The physical examination is effective for one academic year. A prospective student-athlete may lose his/her clearance status if the following are not completed:
    - Athletes are allowed two weeks from the date of their physical examination to provide any additional medical information requested by the team physician.
    - Any student-athlete under the age of 18 must provide a release form signed by his/her parent/guardian within two weeks from the physical examination in order for the Georgia Tech Sports Medicine Department to render medical care and services to the athlete.
    - All prospective student-athletes must provide the Georgia Tech Athletic Association with requested insurance information. All walk-on prospective student-athletes are **required** to have health insurance **before** receiving a physical examination.
    - Student-athletes and/or parents/guardians must sign all consent and acknowledgement forms, waivers and releases of information for Georgia Tech Athletics Association.
- A complete medical history **must** be provided to the athletic trainer or team physician before the physical examination. Failure to report conditions may result in disqualification from intercollegiate activity or delayed clearance to participate in intercollegiate activity.
- The team physician may re-examine any student-athlete and change the student-athlete's status at any time should the situation warrant.
- A complete medical history must be provided to the athletic trainer or team physician before the physical examination. The following conditions must be reported:
    - Injuries to the head, neck, back, upper and lower extremity, and internal organs
    - Fractures, dislocations, strains, sprains and muscle tendon tears
    - Any serious illnesses, previous surgeries or pregnancy
    - Allergies, asthmas, diabetes, or epilepsy
    - Previous counseling of alcohol/substance abuse
    - Cardiopulmonary problems
    - Family history of sudden death
    - Mental/nervous disorders including eating disorders
    - Any condition or illness that limited your ability to participate
- Prospective student-athletes with special conditions may be referred to specialists for examination. Failure to report special conditions will release Georgia Tech from any liability in the event of another injury caused by or related to the unreported condition. Any tests (x-rays included) or referral to specialists to conclude a student-athlete's physical examination may be the financial responsibility of the student-athlete and his/her family.
- Loss of one of the paired organs (e.g. kidney, eye) or any other condition that is determined by the team physician to be detrimental to the student-athlete's health and well-being may disqualify a candidate from participation in intercollegiate athletics.

Medical Treatment

- An athletic trainer will receive, examine and evaluate signs and symptoms presented in order to provide the needed healthcare or, refer to a physician as necessary.
- The Georgia Tech Stamps Health Services has the responsibility for health and welfare of the general student population. The Sports Medicine Department works in conjunction with the Georgia Tech Stamps Health Services to assist with the needs of the student-athletes.
- In case of an emergency or medical problem occurring outside of the normal athletic training room hours, contact an athletic trainer for assistance or advice immediately. Contacting your coach for help in reaching an athletic trainer or obtaining proper assistance may be advisable. If there is a true emergency or life-threatening situation, dial 911. These problems should be immediately referred to the local hospital.
- All treatments and appointments will be conducted by an athletic trainer, under the supervision of a team physician.
- All treatments and doctor's appointments will be handled under the direction of the Sports Medicine Department. Only the team physician, the supervising athletic trainer or director of sports medicine may refer an athlete for outside treatment.
- It is the policy of Georgia Tech Sports Medicine that outside medical treatment for non-athletically related injuries or illnesses **will not** be covered.
- The Sports Medicine Staff must be informed of all referrals prior to the appointment. When applicable, student-athletes may request to have a second opinion. The Sports Medicine Staff will coordinate and pay for the second opinion with a designated physician. However student-athletes who choose to seek outside treatment or referrals on their own, without prior approval, may be responsible for the full cost of services.

NAME	SPORT	GTID#

GEORGIA TECH ATHLETIC TRAINING & SPORTS MEDICINE
WAIVER, ACKNOWLEDGEMENTS AND DISCLOSURE POLICY

1. Under Age 18 Medical Waiver (if applicable)

I, the parent/guardian of (print name/sport)_____ do hereby authorize the Georgia Tech Athletic Training and Sports Medicine Staff, Georgia Tech Stamps Health Services, and other healthcare providers or hospitals to provide treatment and other medical services that are deemed medically necessary.

I have read each of the documents and forms that my student athlete has initialed or signed as a part of the PPE process. I understand the policies of the Georgia Tech Sports Medicine Department and I acknowledge that all information provided is accurate and up-to-date.

_____Date _____Parent/Guardian Signature
_____ Relationship to Student-Athlete _____Parent/Guardian Primary Contact Number

2. Consent for Care Authorization

Permission is hereby granted to the Georgia Tech Athletic Training and Sports Medicine Staff, designated physician, or other medical personnel to proceed with medical or surgical treatment, X-ray examination or other diagnostic imaging, therapy/rehabilitation, mental health evaluation/treatment and/or other medical treatment deemed necessary.

Furthermore, I understand that failure to be compliant with any medial plan of care, as deemed necessary by a Georgia Tech Team Physician and/or member of the Georgia Tech Athletic Training and Sports Medicine Staff, can result in my medical disqualification from all intercollegiate athletic activities.

In the event of serious injury or illness, I understand that an attempt will be made by the appropriate sports medicine personnel and/or athletic department administration to contact my parents or legal guardian. If medical personnel are not able to communicate with the responsible party, the treatment necessary for my health will be provided.

_____ Student-Athlete Signature

3. Concussion Statement

I acknowledge that I have read and understand the NCAA Concussion Fact Sheet. I fully understand and accept my responsibility to report all injuries and illness to the Georgia Tech Athletic Training and Sports Medicine Staff including signs and symptoms of concussions.

_____ Student-Athlete Signature

4. Authorization For Medical Release of Information

I hereby authorize the Georgia Tech Athletic Training and Sports Medicine Department and/or designated physician to release all information with respect to my past, present, and future physical status as may be requested by professional or medical organizations, parents/guardians, media, and professional or amateur organizations.

I understand the GTAA Sports Medicine Department is permitted to disclose information for purposes of payment, health care, treatment, participation status, or as required by law.

Furthermore, I hereby give Georgia Tech Stamps Health Services or designated provider permission to release any/all requested medical records to Georgia Tech Sports Medicine Department if needed for payment, health care, treatment, participation status, or as required by law, of any incurred charges for services rendered at Georgia Tech Stamps Health Services. This release is valid for 1 year from date signed.

_____Student-Athlete Signature

NAME	SPORT	GTID#

GEORGIA TECH ATHLETIC ASSOCIATION SPORTS MEDICINE
ASSUMPTION OF RISK, RELEASE AND WAIVER OF LIABILITY, INDEMNIFICATION, MEDICAL CLEARANCE, AND SCREENING AGREEMENT

Please initial in the space provided and sign at the bottom of page 2 acknowledging that you have read, understand, and agree to the terms herein in order to participate in intercollegiate athletics at Georgia Tech.

1. **Assumption of Risk** Student-Athlete Initial_____

There are inherent risks associated with participation in intercollegiate athletics that include, but are not limited to, death, severe neck and spinal injuries, which may cause complete or partial paralysis, brain damage, severe internal injury, severe injury to bones, joints, ligaments, muscles tendons, and other aspects of the musculoskeletal system. Additionally, there are risks associated with concussions, eye trauma or injury, environmental conditions such as heat or cold illness and dermatologic conditions. It is understood that such injuries may result in serious impairment of future abilities to engage in activities of normal daily living. I hereby assume responsibility for each of these risks and dangers, and all other risks and dangers that could arise out of, or occur during, my participation in intercollegiate athletics or sports medicine modalities.

2. **Release and Waiver of Liability** Student-Athlete Initial_____

I release, waive, discharge, and covenant not to sue Georgia Tech, the Georgia Tech Athletic Association (GTAA) or any subdivision, and their officers and employees, from any liability resulting from personal injury, accident or illness (including death), and/or property loss, however caused, arising from, or in any way related to, my participation in intercollegiate athletics or sports medicine modalities, except for those arising from the willful misconduct, gross negligence, or intentional torts of an applicable Georgia Tech employee.

3. **Indemnification** Student-Athlete Initial_____

I hereby agree to indemnify, defend and hold Georgia Tech and GTAA harmless from any and all claims, actions, suits, procedures, costs, expenses, damages, and liabilities including, but not limited to: attorney fees arising from, or in any way related to, my participation in intercollegiate athletics at Georgia Tech, except for those arising from the willful misconduct, gross negligence or intentional torts of an applicable Georgia Tech employee.

4. **Athletic Medical Clearance** Student-Athlete Initial_____

All student-athletes must complete and pass a pre-participation physical examination (PPE) scheduled and administered through the sports medicine staff, Georgia Tech Sports Medicine team physician or his designee. The PPE, which is effective for the duration of the academic year, will be arranged after preliminary academic eligibility has been provided to the athletic administration. At any time, the team physician may re-examine the student-athlete and change his or her status should the situation warrant.

5. **Medical Treatment** Student-Athlete Initial_____

In accordance with NCAA rules, GTAA Sports Medicine may provide a student-athlete's medical expenses resulting from any injury or illness regardless of whether the injury or illness occurs during the academic year or summer period. It is the policy of GTAA Sports Medicine to provide student-athlete medical expenses for those injuries or illness that are the result of athletic practice or competition. GTAA Sports Medicine will not provide medical expenses for illness or injury resulting outside your collegiate sport.

Student-athletes must report injuries/illnesses occurring as a result of practice/competition to the athletic trainer. GTAA will not be responsible for medical expenses resulting from injuries/illness not reported.

6. **Sickle Cell Trait Screening** Student-Athlete Initial_____

In accordance with NCAA mandates, ALL student-athletes must be tested for sickle cell trait prior to any athletics participation. I acknowledge that I have read and understand the NCAA Sickle Cell Trait Fact Sheet and will either 1. Provide proof of sickle cell testing performed at birth, or 2. Return results of a recent lab screening (blood test), along with medical forms. I understand that there are NO exceptions to this policy and that failure to provide results may result in delayed athletic medical clearance.

NAME	SPORT	GTID#

7. Insurance Student-Athlete Initial_____

GTAA is not a primary insurance provider. It is the policy of the Georgia Tech Sports Medicine Department that all student-athletes submit primary and secondary insurance information. If an injury occurs, your insurance information will be submitted to the prospective provider. The provider will then file with your personal group insurance. The Georgia Tech Athletics secondary insurance or the Sports Medicine Department will pay the difference and you will incur no cost for an intercollegiate injury. This should not affect your policy premium and in many cases will help you meet your existing deductibles.

8. GTAA Sports Medicine Policies and Procedures Student-Athlete Initial_____

I have read and understand all Georgia Tech Athletic Training and Sports Medicine medical documents and forms. I further understand that GTAA Sports Medicine, specifically the Director of Sports Medicine and/or athletics administrators reserves the right to use discretion regarding student-athlete welfare decisions on a case by case basis.

Acknowledgement of Understanding

My signature below is my acknowledgment of reading and understanding this Agreement.

Student-Athlete signature: Date:

_____ _____

Parent/Guardian signature (if required): Date:

_____ _____

NAME	SPORT	GTID#:

I verify that I have read, understand and will comply with the Georgia Tech Athletic Training Room Policies and Standards of Care listed below.

Signature _____ Date _____

Georgia Tech Sports Medicine
Student-Athlete Rights, Responsibilities and Standards of Care

As a coeducational department and facility, during therapy or while in the facility, everyone will be expected to behave in an appropriate matter. The following guidelines reflect our assurance that we will provide a standard of care and not compromise.

In order to maintain a professional environment and ensure quality and positive student athlete outcomes, below are the responsibilities, rights, and expectations of student athlete receiving care from members of the Georgia Tech Athletic Medicine Team.

Responsibilities as a Student Athlete/Patient:

- You have the responsibility to report injuries and illnesses your attending athletic trainer.
- You have the responsibility to be actively involved in all aspects of your care, treatment and rehabilitation as directed by the attending athletic trainer and physician.
- You have the responsibility to give truthful and complete information about your current health and health history, to the best of your knowledge. Failure to provide the complete and accurate information may impact care, treatment plan, clearance and/or return to activity.
- You have the responsibility to comply with the treatment plan for your care, which includes home care instructions, taking prescribed medications, and rehabilitation protocols.
- You have the responsibility to accept the consequences if you refuse treatment or do not follow your treatment plan or instructions.
- You have the responsibility to be considerate and respectful of staff and other student athletes, which includes respecting others privacy and not sharing any person's private medical history or information.

Rights as a Student Athlete/Patient:

- You have the right to be treated with dignity and respect. Know that your condition and care will only be shared with those athletic medicine staff members who are involved with your care and treatment. At no time will your care be discussed or shared with student athletes or staff who are not directed involved in your care
- You have the right to be involved in making decisions about your care, including pain control. In addition, you may have your family or caregiver assist with these decisions.
- You have the right to be informed about your medical condition and any treatments the attending athletic trainer and physician prescribe.
- You have the right to withhold consent for any treatments and accept responsibility for the consequences of refusing treatments.
- You have the right to be informed of the persons who may be involved in your care and made aware of the individuals who may be present in the examination room during evaluations.
- You have the right to safety and privacy, including a safe environment of care

Treatment Expectations:

- Student-athletes will be treated in the order they enter the athletic training rooms, unless there is an emergency situation.
- Being in the athletic training room does not excuse any student-athlete from class, study hall, or tutoring.
- All student-athletes must wear appropriate attire, which includes short and T-shirts.
- Any behavior that is determined to be inappropriate will be corrected by one of the staff athletic trainers.
- Towels and shorts are not to be removed from the athletic training rooms.
- The use of inappropriate language will not be allowed in the athletic training rooms.
- Student-athletes may not use computers without permission of a staff athletic trainer.
- All backpacks and personal items are to be placed in the cabinets located next to the front door.
- All student-athletes must shower after practice/workouts before receiving treatment
- Records of treatment attendance are open to all coaches for review.
- All medical equipment will be operated by a member of the sports medicine staff. All equipment and supplies must remain in the athletic training room unless permitted by an athletic trainer.
- GTAA Policy is that student-athletes will not consume any dietary supplement that is not given to him/her by the sports medicine department or the sports nutrition department.

Georgia Tech Sports Medicine
Information Regarding Sickle Cell Trait Screening

In accordance with recent NCAA mandates, the policy and procedure at GT is that all incoming student-athletes are tested for the sickle cell trait prior to any athletics participation, including practice, or lifting.
Persons of any race, gender and ancestry may test positive for sickle cell trait. Within the past ten (10) years, eight (8) collegiate athletes have died from acute rhabdomyolysis, a result of carrying the sickle cell trait. Some of these players were unaware that they had the trait.

If you have been previously tested for sickle cell trait, contact your family physician, pediatrician, or Health Department to obtain copies of these results. One test per lifetime is sufficient.
If you have never had a lab screening (blood test) for sickle cell trait, or are unable to obtain prior results, then you should schedule one immediately. Typically, the blood test will take 48-72 hours to be finalized and documented results provided.

Please return previous results OR current results along with the Pre-Participation Physical Examination Medical and Insurance Forms to the Georgia Tech Sports Medicine Department. Otherwise, the student-athlete will not be cleared by the Georgia Tech Team Physician to participate in workouts, practice and any other form of athletic participation. THERE ARE NO EXCEPTIONS TO THIS POLICY.

If a student-athlete tests positive for sickle cell trait, a member of the Sports Medicine Department will discuss the inherent health risks and precautions to help avoid sickle cell trait-related problems during his/her pre-participation physical exam. A positive sickle cell trait result does not jeopardize a student-athletes status or eligibility to compete for GT. Positive results may also mean adjustments in the student-athlete's initial conditioning and practice schedule.

Please contact us immediately if you have any questions regarding this policy.

_____Student-Athlete Signature

GEORGIA TECH SPORTS MEDICINE
INITIAL MEDICAL HISTORY
(INCOMING STUDENT-ATHLETE)

Please Print Legibly

Name:	**Sport:**	**GTID#:**
Sex: ☐ **M** ☐ **F** **Birth Date (MM/DD/Year)**	**Age:**	**SS#:**
Race: ☐ **Caucasian** ☐ **Afro-American** ☐ **Asian/Pacific** ☐ **Alaskan/Indian** ☐ **Hispanic** ☐ **Other**_____		
Class: ☐ **FR** ☐ **SO** ☐ **JR** ☐ **SR** ☐ **5th**	**Athlete Cellphone #**	
Home Address:	**City/State/Zip:**	
Home Phone #:	**Athlete Email:**	
Parent/Guardian Name:	**Relationship to Athlete:**	
Parent/Guardian Home Address (if different from above):		
City/State/Zip:	**Parent/Guardian Primary Email Address**	
Parent/Guardian Primary Contact #: ☐**Mobile** ☐ **Home**	**Parent/Guardian Secondary Contact #:** ☐ **Mobile** ☐ **Home**	

GENERAL MEDICAL HISTORY (If YES, explain)	**YES**	**NO**
ARE YOU ALLERGIC TO ANY MEDICATIONS? If "YES", list medications		
ARE YOU ALLERGIC TO FOOD OR OTHER ITEMS? IF "YES", list items		
Asthma: If "YES", List Medication and Usage		
Diabetes:		
Epilepsy:		
Fainting Spells:		
Frequent Nose Bleeds:		
Heart Trouble-personal history:		
Rheumatic Fever:		
Hepatitis:		
Mononucleosis:		
Mental Illness/Nervous disorder:		
Anxiety:		
Eating Disorder:		
Prior or present substance abuse/counseling:		
Loss of pair organ:		
Pregnancy:		
Environmental Illness: (example: heat or cold illness)		
Family History: Sudden Death: (list family member below)		

ORTHOPAEDIC HISTORY (If YES, explain)	**YES**	**NO**
Hand/Fingers:		
Wrists:		
Arms:		
Elbows:		
Shoulder/Clavicle/Chest:		
Pelvis/Hips/Groin:		
Thigh(s)/Upper Leg:		
Knee(s):		
Lower Leg(s):		
Ankle(s):		
Feet/Toes:		
Spine/Back:		
Head/Neck:		
History of Stress Fractures:		
Concussions:		
If "YES" to concussions, list the # of incidences, dates & return to play		

Sickle Cell Trait Screening (attach screening results) ☐ **Positive** ☐ **Negative** ☐ **Unknown**

Have you received your COVID-19 vaccination? YES ☐ **NO** ☐ **If Yes, what dose?**_____ **Dates? 1st** _____ **2nd** _____ **Booster?**_____

Have you had an eye injury? ☐ YES ☐ NO List injury and date	List serious illnesses, syndromes diseases or previous surgeries (explain)
Do you wear: ☐ Glasses ☐ Contacts Glasses: ☐ Reading ☐ Athletics Contacts: ☐ Hard ☐ Soft	List current medications (explain use)
Date of recent tetanus shot	Do you have body piercings ☐ YES ☐ NO If "YES" list location(s)

READ BELOW AND SIGN

I verify that all of the above information is accurate and complete. I understand that failure to disclose previous medical conditions may result in removal from the team and/or loss of athletic-related financial aid. Also, I understand that the Georgia Tech Sports Medicine Department is not responsible for expenses related to pre-existing conditions that are not a direct result or occurred during athletic participation.

Signature of Athlete:	Date:
Signature of Parent/Guardian: (if S-A under age 18)	Date:

GEORGIA TECH SPORTS MEDICINE
CARDIOVASCULAR HEALTH QUESTIONNAIRE

NAME	SPORT	GTID#

Directions: Check (☑) the appropriate box and provide explain or list where applicable

FAMILY HEALTH

1. Has anyone in your family ever died suddenly before the age 55? ☐ YES ☐ NO
2. Has anyone in your family ever had a heart attack before the age of 55? ☐ YES ☐ NO
3. Have you or any relative been diagnosed as having Marfan's Syndrome? ☐ YES ☐ NO
4. Have you or any relative been diagnosed as having hypertrophic cardiomyopathy (HCM) or IHSS? ☐ YES ☐ NO

PERSONAL HEALTH

1. Have you ever fainted or "passed out" during exercise? ☐ YES ☐ NO

   Explain episode _____

2. Have you experienced chest pain, tightness, pressure or any discomfort during exercise? ☐ YES ☐ NO
3. Have you ever been told that you have high blood pressure? ☐ YES ☐ NO
4. Have you ever been told that you have a heart murmur? ☐ YES ☐ NO
5. Have your ever been told that you have a "heart problem"? ☐ YES ☐ NO
6. Does your heart ever beat fast or skip a lot of beats? ☐ YES ☐ NO
7. Have your ever been restricted from sports competition? ☐ YES ☐ NO

   Explain _____

8. Have you ever been hospitalized for any non-orthopaedic reason? ☐ YES ☐ NO

   Explain _____

9. List any/all supplements, herbs or proteins that you take, other than vitamins. ☐ YES ☐ NO

   List _____

I verify that all of the above information is accurate and up to date. I understand that failure to disclose previous medical conditions may result in removal from the team and/or loss of athletic financial aid. Also, I understand that the Georgia Tech Sports Medicine Department is not responsible for expenses related to previous conditions.

Name (signature) _____ Date _____

Parent/Guardian (signature) _____ Date _____

GEORGIA TECH SPORTS MEDICINE
WOMEN'S HEALTH QUESTIONNAIRE

NAME	SPORT	GTID#

Directions: Check (☑) the appropriate box and provide explain or list where applicable

MENSES

1. Age of first menstrual cycle _____ years old
2. Duration of menstrual cycle _____ days
3. Is your menstrual cycle regular? (regular=one per month) ☐ YES ☐ NO

   Explain (if not regular) _____

4. Are you currently taking birth control medication ☐ YES ☐ NO

   List birth control medication: _____

5. Do you ever experience the following during or in between your menstrual cycle? (check all that apply)

☐ Heavy Bleeding ☐ Severe Cramping ☐ Spotting ☐ Pain ☐ Discharge

OB/GYN

1. Have you ever had a gynecological exam? ☐ YES ☐ NO

   Date: _____

2. Have you ever had a pap smear? ☐ YES ☐ NO

   Date: _____

3. Have you ever had an abnormal pap smear? ☐ YES ☐ NO

   Date: _____

MEDICAL HISTORY

1. Have you ever been diagnosed with a stress fracture(s) ☐ YES ☐ NO

   Explain (include location of stress fracture, date, time missed from activity) _____

2. Have you ever been diagnosed with anemia? ☐ YES ☐ NO

   Explain (include information about diagnosis, medications, current condition) _____

NUTRITIONAL HISTORY

Do you consider yourself a vegetarian? ☐ YES ☐ NO

Do you take any supplements? (examples: multi-vitamins, calcium, iron, etc.)

List: _____

MEDICAL INSURANCE AND AUTHORIZATION FORM

STUDENT-ATHLETE INFORMATION

Athlete Legal Name_____
Social Security Number _____
Email_____

Sport _____
Date of Birth _____
Cell Phone _____
GT ID _____

PARENT/GUARDIAN EMERGENCY & CONTACT INFORMATION

Parent/ Guardian 1 _____
Home Address_____
City/State/Zip_____
Phone # _____
Employer _____
Email_____

Parent/Guardian 2_____
Home Address_____
City/State/Zip_____
Phone# _____
Employer _____
Email_____

INSURANCE INFORMATION

Policyholder's Name_____
DOB_____Relationship to Athlete_____

PLEASE ATTACH A LEGIBLE COPY OR PICTURE OF YOUR INSURANCE CARDS BELOW
PLEASE CROP THE IMAGE TO THE CARD ONLY

Please attach a legible copy or picture of PRIMARY insurance card.
-FRONT-

Please attach a legible copy or picture of PRIMARY insurance card.
-BACK-

Type of plan: HMO PPO POS Other_____
Coverage: Medical Pharmacy Dental Mental

Please attach any additional insurance coverage (if applicable)
-FRONT-

Please attach any additional insurance coverage (if applicable)
-BACK-

Please attach DENTAL Insurance Card (if applicable)
-FRONT-

Please attach DENTAL Insurance Card (if applicable)
-BACK-

_____My student-athlete does NOT have medical insurance coverage.

Signature of Parent/Legal Guardian Date

AUTHORIZATION AND RELEASE OF INFORMATION STATEMENT

I hereby certify that I have read the answers to all parts of this form and to the best of my knowledge and belief, the information contained is complete and correct as herein given. I hereby authorize the Georgia Tech Athletic Association to file a claim under the group medical policy or policies shown above on my/our behalf for an athletic injury I sustained. I authorize that amounts payable under this policy, for an athletically related injury, be paid directly to the medical provider or to the Georgia Tech Athletic Association.

Furthermore, I authorize and direct any physicians or medical facilities, insurance company, or other organization, institution or person, providing treatment, to disclose and release to government agencies, insurance carriers, Georgia Tech Athletic Association or others who are financially liable for my hospitalization and medical care, all information needed for payment to such providers. Additionally, I permit the aforementioned representatives to examine and make copies of all records relating to such care and treatment. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of Student-Athlete Date

_____ _____
Signature of Parent/Guardian Date

A FRONT AND BACK COPY OF YOUR INSURANCE CARD(s) MUST BE PROVIDED WITH THIS FORM

Medical Record Number: _____
(for internal purposes)

EMORY HEALTHCARE

AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION
HEALTH INFORMATION MANAGEMENT DEPARTMENT

Patient Name: _____ Last 4 digits of SSN: _____

Previous Name, if applicable: _____

Address: 150 Bobby Dodd Way City: Atlanta State: GA Zip Code: 30332

Date of Birth: _____ Home Phone: _____ Work Phone: _____

Email address _____

1. **EMORY HEALTHCARE FACILITY/FACILITIES:**

I authorize representatives from the following facility/facilities to disclose the health information as directed below:

(Check one or more):

- ☑ The Emory Clinic
- ☑ Emory University Hospital
- ☑ Center for Rehab. Medicine
- ☑ Emory Children's Center
- ☑ Emory Specialty Associates
- ☑ Dialysis Access Center of Atlanta
- ☑ Emory Saint Joseph's Hospital of Atlanta
- ☑ The Medical Group of Saint Joseph's, LLC
- ☑ Other: Ga. Tech Athletics
- ☑ Emory Johns Creek Hospital
- ☑ Emory University Hospital Midtown
- ☑ Emory University Orthopaedics and Spine Hospital
- ☑ Emory University Hospital at Wesley Woods
- ☑ Budd Terrace
- ☑ Emory Decatur Hospital
- ☑ Emory Long Term Acute Care
- ☑ Emory Hillandale Hospital
- ☑ DeKalb Medical Physician Group

2. **RECEIVING PARTY, FORMAT, AND METHOD OF DELIVERY:**

FORMAT:

- ☑ On Paper
- ☐ On CD
- ☐ Flash Drive

METHOD OF DELIVERY:

- ☐ Mail (Complete info below)
- ☐ Pick up (List by whom below)
- ☐ EHC Electronic Release of Information Request Website (In order to receive records via the electronic website, you must create an account through the website, then submit your request via the website. Please see attached instructions)
- ☑ Via Email (Please provide email address above) Please note, due to file size limits for our organization, records sent via email are restricted to a small number of pages.

Name: Georgia Tech Sports Medicine - sportsmed@athletics.gatech.edu

Address: 150 Bobby Dodd Way

City: Atlanta State: GA Zip Code: 30332

Telephone Number: 404 894 5460

Fax Number (continuing patient care support only): 404 894 0695

3. **DESCRIPTION OF HEALTH INFORMATION TO BE DISCLOSED:**

- ☑ Complete medical record *(Please specify dates of service)* _____
  OR
- ☐ Partial Medical Record *(Please specify records below)*
- ☐ Continuity of Care/Abstract *(please specify dates of service)* _____
- ☐ *You must check this box if you are also requesting Billing Records*

Information	Dates	Information	Dates
☑ History & physical	_____	☑ Office notes/Progress notes	_____
☑ Consultations	_____	☑ Operative reports	_____
☑ Discharge summary	_____	☑ Pathology reports	_____
☑ Lab results	_____	☐ Pathology slides	_____
☐ X-rays	_____	☑ EKG reports	_____
☐ CD/Films	_____	☐ Photo/Videos	_____
☐ Cath Record	_____	☐ ED Record	_____
☐ Itemized Bill	_____	☐ Rhythm Strips	_____
☐ Other *(Please specify dates of service):*		☐ Pathology Slides	_____

4. **PURPOSE OF DISCLOSURE**

- ☑ At my request Need Records Certified ☐ Yes ☐ No
- ☐ Other: _____

Medical Record Number: _____
(for internal purposes)

5. **IMPORTANT NOTICE**

If you are requesting your medical information via e-mail, please be sure that you have provided us with an accurate e-mail address. E-mail and attachments will be sent to you in an encrypted format with instructions on how you retrieve the information. Once you receive the e-mail we encourage you to maintain the information in a secure manner and use caution when forwarding or allowing access to your e-mail. Also, the CD or flash drive you receive containing your medical health information may not be encrypted or password protected. Once you have received your medical information from EHC we encourage you to take precautions to protect the data on the device through encryption or storing the device in a secure manner. By choosing to receive **your health information** on a CD or flash drive, you are acknowledging and accepting these risks.

6. **EXPIRATION OF AUTHORIZATION**

Unless I request in writing otherwise, I understand that this authorization will expire on _____ *(Insert expiration date or event)*. If I do not specify an expiration date or event, this authorization will expire ninety (90) days from the date on which I signed this authorization.

7. **RIGHT TO REVOKE AUTHORIZATION**

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department(s) of the Emory Healthcare facility or facilities checked above. A list of addresses for the Medical Records Departments is contained in the Emory Healthcare, Inc. Notice of Privacy Practices. I understand that the revocation will not apply to any health information that has already been released in response to this authorization.

8. **RE-DISCLOSURE**

I understand that if my health information is disclosed to a party other than a health care provider, health plan or health care clearinghouse subject to the federal privacy regulations, my health information disclosed pursuant to this authorization may no longer be protected by the federal privacy regulations.

9. **FEES**

I understand that federal and state laws allow a fee to be charged for the copying of patient records and I will be responsible for the payment of such fees.

10. **REFUSAL TO AUTHORIZE USE AND/OR DISCLOSURE**

If I have been asked to sign this form in order to authorize the disclosure of my health information for purposes related to research, or for other reasons, I understand that Emory Healthcare may decline to treat me if I refuse to sign this authorization only if: (1) the treatment would be related to a research project and this authorization is for the use or disclosure of my health information such research; or (2) the treatment would be for the sole purpose of creating health information for disclosure to a third party (such as a workers compensation examination).

11. **RELEASE AND WAIVER**

If the health information that I have requested Emory Healthcare to disclose contains any privileged psychiatric or psychological information related to the treatment of physical and/or mental illness, chemical dependency or alcohol abuse, or testing or treatment of any communicable or infectious disease such as acquired immunodeficiency syndrome (AIDS), Immunodeficiency Syndrome Related Complex (ARC), human immunodeficiency virus (HIV), Venereal Disease, Tuberculosis, or Hepatitis, I hereby waive any privilege concerning such information for the purpose(s) of releasing it to the party or parties authorized above. I also release Emory Healthcare, each of the Emory Healthcare facilities checked above, and their officers, trustees, agents and employees from any and all liabilities, damages and claims, which might arise from the release of the health information authorized by me above.

_____	_____	_____
Signature of Patient (or Patient's Representative)	Date	Time
_____	_____	
Printed Name	Description of Authority to Act for Patient	

NOTE: A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE PROVIDED TO THE PATIENT AND/OR PATIENT'S REPRESENTATIVE AND A COPY MUST BE PLACED IN THE PATIENT'S MEDICAL RECORD

NCAA Medical Exception Documentation Reporting Form
to Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
and Treatment with Banned Stimulant Medication

- Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
- Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (see Drug Testing Exceptions Procedures at www.ncaa.org/drugtesting).

To be completed by the Institution:

Institution Name:_____

Institutional Representative Submitting Form:
Name_____
Title_____
Email_____
Phone_____

Student-Athlete Name_____
Student-Athlete Date of Birth_____

To be completed by the Student-Athlete's Physician:

Current Treating Physician (print name):_____
Specialty:_____
Office address_____
Physician signature:_____ Date_____

Check off that documentation representing each of the items below is attached to this report

- o Diagnosis.
- o Medication(s) and dosage.
- o Blood pressure and pulse readings and comments.
- o Note that alternative non-banned medications have been considered, and comments.
- o Follow-up orders.
- o Date of clinical evaluation: _____
- o **Attach written report summary of comprehensive clinical evaluation. Please note that this includes the original clinical notes of the diagnostic evaluation.**
  The evaluation should include individual and family history, address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation, such as completed ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores.
  The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

DISCLAIMER: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder.

A FACT SHEET FOR STUDENT-ATHLETES

SICKLE CELL TRAIT

WHAT IS SICKLE CELL TRAIT?

Sickle cell trait is not a disease. Sickle cell trait is the inheritance of one gene for sickle hemoglobin and one for normal hemoglobin. Sickle cell trait will not turn into the disease. Sickle cell trait is a life-long condition that will not change over time.

- During intense exercise, red blood cells containing the sickle hemoglobin can change shape from round to quarter-moon, or "sickle."
- Sickled red cells may accumulate in the bloodstream during intense exercise, blocking normal blood flow to the tissues and muscles.
- During intense exercise, athletes with sickle cell trait have experienced significant physical distress, collapsed and even died.
- Heat, dehydration, altitude and asthma can increase the risk for and worsen complications associated with sickle cell trait, even when exercise is not intense.
- Athletes with sickle cell trait should not be excluded from participation as precautions can be put into place.

DO YOU KNOW IF YOU HAVE SICKLE CELL TRAIT?

People at high risk for having sickle cell trait are those whose ancestors come from Africa, South or Central America, India, Saudi Arabia and Caribbean and Mediterranean countries.

- Sickle cell trait occurs in about 8 percent of the U.S. African-American population, and between one in 2,000 to one in 10,000 in the Caucasian population.
- Most U.S. states test at birth, but most athletes with sickle cell trait don't know they have it.
- The NCAA recommends that athletics departments confirm the sickle cell trait status in all student-athletes.
- Knowledge of sickle cell trait status can be a gateway to education and simple precautions that may prevent collapse among athletes with sickle cell trait, allowing you to thrive in your sport.

HOW CAN I PREVENT A COLLAPSE?

- Know your sickle cell trait status.
- Engage in a slow and gradual preseason conditioning regimen.
- Build up your intensity slowly while training.
- Set your own pace. Use adequate rest and recovery between repetitions, especially during "gassers" and intense station or "mat" drills.
- Avoid pushing with all-out exertion longer than two to three minutes without a rest interval or a breather.
- If you experience symptoms such as muscle pain, abnormal weakness, undue fatigue or breathlessness, stop the activity immediately and notify your athletic trainer and/or coach.
- Stay well hydrated at all times, especially in hot and humid conditions.
- Avoid using high-caffeine energy drinks or supplements, or other stimulants, as they may contribute to dehydration.
- Maintain proper asthma management.
- Refrain from extreme exercise during acute illness, if feeling ill, or while experiencing a fever.
- Beware when adjusting to a change in altitude, e.g., a rise in altitude of as little as 2,000 feet. Modify your training and request that supplemental oxygen be available to you.
- Seek prompt medical care when experiencing unusual physical distress.

For more information and resources, visit www.NCAA.org/health-safety

CONCUSSION

A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

HOW CAN I PREVENT A CONCUSSION?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

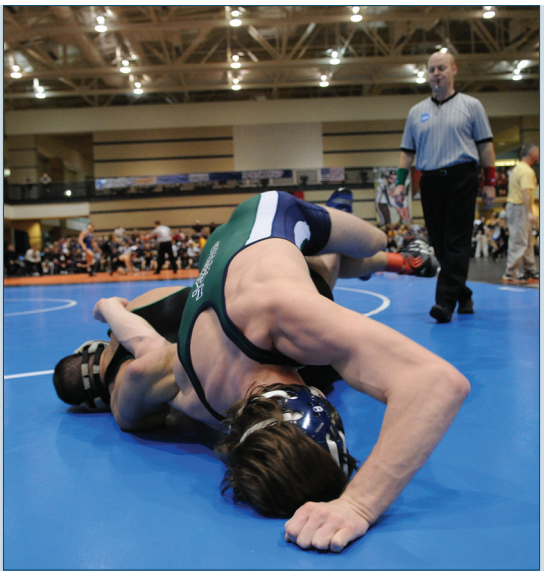
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell your athletic trainer and coach**.** Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.



IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.

Reference to any commercial entity or product or service on this page should not be construed as an endorsement by the Government of the company or its products or services.