Parental Consent Form

LYNDHURST HIGH SCHOOL DEPARTMENT OF ATHLETICS

Student Name: a a Address: 9 Belleville Avenue Bloomfield, New Jersey 07003

Telephone: (234)234-2345 Grade: 10 Birthdate: 02/03/2001

In order to participate in Interscholastic Sports, a student must have this form completed prior to the first day of practice. The Medical History Questionnaire and Medical Index Card are to be completed by your parent/guardian. The physical examination section must be completed by the school physician or your family doctor. Each candidate for a place on a school athletic team shall be given a medical examination by the medical inspector or designated team doctor no more than 60 days prior to the first practice session, or in lieu thereof, the medical inspector may accept the report of such an examination by a physician licensed to practice medicine. Each candidate must undergo one medical examination in each school year. A medical re-evaluation shall be given to every athlete who has been previously injured in any sport and intends to participate in the following seasonal sport activity. I hereby give my consent for my child to participate in the athletic program sponsored by Lyndhurst High School as listed below.I am aware of the inherent risk of injury in all sports. I/we acknowledge that even with the best of coaching, use of the most advanced protective equipment and strict observance of rules, injuries are still a possibility. I realize the risk may be severe, including the risk of fractures, total disability, brain injuries, paralysis even death. I/we acknowledge that I/we have read and understand this warning. I have read all the information herein and grant permission to my son/daughter to participate in Inter Scholastic Athletics.

Date: 10/10/2014 Parent's Signature: 

For the Student

I understand that in order to participate, I must:

1. Have on file in the Athletic Department Office a Consent Form signed by my parent or guardian, giving his/her approval.
2. Have a completed Emergency Information for Athletic Participants Card on file in the office of the Athletic Trainer.
3. Pass a comprehensive physical examination given by the school physician.
4. Be eligible according to New Jersey Interscholastic Athletic Association our affiliated league and Lyndhurst High School rules, Le. academic attendance and disciplinary rules.
5. Agree to obey all regulations pertaining to the practice periods and squad rules as established by the coaches and to conduct myself in a courteous manner both on and off the field. track and/or court at all times.
6. Be responsible for knowing special regulations and penalties for violation of school rules concerning athletics.
7. Be responsible for the care of and safe return of all school equipment issued to me and to pay for equipment damaged or not returned at the original cost of said equipment.

Date: 10/10/2014 Student's Signature: 

Fall Sport: **Winter Sport:** Basketball (G) **Spring Sport:**

Known Allergies: None

Glasses: No

Contacts: No

The team physician, trainer and coach may apply first aid treatment until the family doctor can be contacted. **Yes**

We give our consent for team physician, trainer and coaches to use their own judgement in securing medical aid and ambulance service in case the parents cannot be reached. **Yes**

Preferred Hospital: Nyack

Date of last tetnus: 02/04/2014

Date: 10/10/2014

Parent' Signature

Emergency Information For Athletic Participants

LYNDHURST HIGH SCHOOL, DEPT. OF ATHLETICS

Athlete's Name: a a **Grade:** 10

Birthdate: 02/03/2001 **Age:** 12

Address: 9 Belleville Avenue Bloomfield, New Jersey 07003

Home Phone: (234)234-2345

Phone No. of Parents during day:

Mother: (201)564-7381

Father:

In an emergency, if Parents cannot be contacted, notify:

Name: Greg Becker **Phone:** (845)429-8923

Family Doctor: Richard King

Doctor's Phone No.: (845)555-8888

PLAYING IT SAFE

Cardiac Screening Intake Form

Patient Information

First Name: a	Last Name: a
Date of Birth: 02/03/2001	
Address: 9 Belleville Avenue	
City: Bloomfield	State: New Jersey Zip: 07003
Telephone: (234)234-2345	Second Phone: (201)564-7381
Parent/Guardian Name: Forest Becker	
Primary Physician: Richard King	
Physician's Address: 1 Congers Road	Congers, New Jersey 09876
Physician's Telephone: (845)555-8888	
Physician's Fax Number:	

Patient History:

No 1. Has your child fainted or passed out DURING exercise, emotion, or startle?
No 2. Has your child fainted or passed out AFTER exercise?
No 3. Has your child had extreme fatigue associated with exercise different than other children?
No 4. Has your child ever had unusual/extreme shortness of breath during exercise?
No 5. Has your child ever had discomfort, pain, or pressure in his/her chest during exercise or complained of his/her heart “racing” or skipping beats?
No 6. Has a doctor ever told you that your child has high blood pressure, high cholesterol, heart murmur, or a heart infection?

No 7. Has a doctor ever ordered a test for your child’s heart?
No 8. Has any treatment been necessary?
No 9. Has your child ever been diagnosed with an unexplained seizure disorder or exercise-induced asthma?

Family History Questions:

No 1. Have any family members experienced sudden, unexpected death before age 50? (Including sudden infant death syndrome (SIDS), car accident, drowning, and other causes?)
No 2. Have any family members died suddenly of “heart problems” before age 50?
No 3. Have any family members experienced unexplained fainting or seizures?
4. Are there relatives with conditions such as:
   - **No** Hypertrophic Cardiomyopathy (HCM)
   - **No** Dilated Cardiomyopathy (DCM)
   - **No** Aortic rupture of Marfan Syndrome
   - **No** Coronary artery atherosclerotic disease (heart attack at age 50 or younger)
   - **No** Arrhythmogenic Right Ventricular Cardiomyopathy (ARVC)
   - **No** Long QT Syndrome (LQTS) or Short QT Syndrome
   - **No** Brugada Syndrome (Heart rhythm disorder characterized by an abnormal heartbeat called "Brugada")
   - **No** Catecholaminergic Polymorphic Ventricular Tachycardia (CPVT)
   - **No** Primary pulmonary hypertension (lung hypertension)
   - **No** Pacemaker orimplanted cardiac defibrillator
   - **No** Congenital deafness (deaf at birth)

*Family and patient history are an important part of screening for cardiac conditions. If you choose not to complete this form, or are otherwise unable to provide complete or accurate answers regarding family or the child’s own history, the cardiac screening of your child may not be as thorough as possible.Barnabas Health Outpatient Centers may or may not collect this form at the same time as performing tests today on your child. Even if this form is collected today, Barnabas Health Outpatient Centers shall not be responsible for reviewing the information that you choose to include on this form, but if you do complete this form and provide it to Barnabas Health Outpatients Center today, then the form, and the information you provide, may be shared by Barnabas Health with your child’s pediatrician and a referring cardiologist if your child is found to have a cardiac condition which requires further evaluation.Whether or not you provide a completed form today to Barnabas Health, we encourage you to fill out this form as correctly and completely as possible, and discuss the contents of this form with your child's pediatrician, as an additional cardiac screening tool.

Barnabas Health

INFORMED CONSENT
FOR PRE-PARTICIPATION CARDIOVASCULAR SCREENING

Patient Name: a a

REQUEST AND PERMISSION FOR CARDIOVASCULAR SCREENING

1. Permission. I hereby request and authorize Saint Barnabas Medical Center and its employees, medical staff and agents (collectively, "SBMC") to perform cardiovascular screening (the "Screening") on me (my child). I understand that such Screening will involve the taking of an abbreviated medical history focused on cardiac health and performance of an EKG. On the basis of this Screening, I (my child) may be referred to specialists for additional testing. I also understand that there are other higher level screening tests that could be performed, such as echocardiograms and exercise testing, but will not be performed as part of the Screening, and I should discuss the need for higher level screening with my (my child's) physician. I understand that in no event will I (my child) be treated for any condition, given a definitive diagnosis or given recommendations regarding continued participation in sports or athletic events solely on the basis of the Screening.

2. Objectives of the Screening. In a very limited number of occasions, individuals who participate in sports and athletic events have a specific risk factor(s) that make such individuals predisposed to a cardiac arrest and/or sudden death during, or immediately following such athletic activities (the "Specific Risk Factor"). I understand that the objective of the Screening is to evaluate whether I (my child) may require further cardiovascular testing or intervention to identify a Specific Risk Factor. I understand that the Screening is neither a comprehensive exam, nor a medical clearance for participation in such sports and athletic events, and I (my child) will not be evaluated for other conditions that are unrelated to my (my child's) cardiac function. I understand that, regardless if I (my child) participate(s) in the Screening, I should consult with my (my child's) physicians if I (my child) intend(s) to participate in any sports or athletic activities. Furthermore, if I have any concerns regarding my (my child's) physical condition, I (my child) should seek additional medical evaluation and treatment.

3. Inherent Risks. I further understand that there are inherent risks in participating in sports and other athletic events and participation in the Screening will not reduce the inherent risks associated with sports or athletic events. Furthermore, the Screening does not reduce the risks associated with having a Specific Risk Factor, and therefore, even if the Screening leads to a referral, cardiac arrest or death could occur, whether or not participating in sports or other athletic events.

4. Other Causes. There are other possible causes of cardiac arrest and sudden death in athletes unrelated to the Specific Risk Factors, including, without limitation, use of illicit drugs, eating disorders and accidents. I understand that the Screening is not designed to identify all of the other causes of cardiac arrest or sudden death, and therefore, if any of these other causes occur or are present, I (my child) am (is) at risk for physical harm or injury, including sudden death, even though the Screening does not identify such issues. I understand that I should discuss these other causes with my (my child's) physician who can provide advice regarding evaluation or treatment, as necessary.

5. Explanation of Screening. The procedure(s) involved in the Screening have been explained to me and I have been provided with the necessary information for me to evaluate the risks and benefits of the proposed Screening. I have also received information regarding: (a) the nature and purpose of the Screening; (b) alternatives to the Screening, as well as the relevant risks and benefits of such alternative procedures; (c) clinical outcome if I do not elect to have the Screening; (d) the potential benefits and possible risks, side effects and complications associated with the Screening; and (e) the likelihood of achieving the goals of Screening. I have been given an opportunity to ask questions and all my questions have been answered satisfactorily.

6. No Guarantees. I am aware that there are certain risks and hazards connected with any treatment or screening that may result in complications or other consequences. I also know that no one can predict with certainty the results of medical treatment or screening because the practice of medicine is not an exact science. I acknowledge that no guarantees or assurances have been made to me concerning my (my child's) Screening. I understand that this Screening is only able to identify a certain limited number of Specific Risk Factors associated with cardiac conditions and that there are other symptoms and Specific Risk Factors that cannot be identified by the Screening. Therefore, regardless of the results of the Screening, I am not guaranteed that I (my child) do (does) not have a Specific Risk Factor. I am aware that unforeseen Specific Risk Factors may develop after the Screening, particularly in adolescents, and if I (my child) am (is) in high school, I (my child) should have the Screening repeated at least every two years (and every 3-4 years for college-age individuals) or earlier if symptoms develop and/or manifest. I understand that during the course of the Screening, additional conditions may be identified (although there is no guarantee that each and every condition that is present will be identified).

7. Understanding of this Form. I confirm that I have read and understand the above and all the blank spaces have been completed prior to my signing. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction.

Parent/Relative or Guardian:  Name: Forest Becker Date: 10/10/2014

Relationship If Signed By Other Than Patient: Father

Witness/Interpeter: _____ Name: _____ Date: _____

Barnabas Health

MATTHEW J. MORAHAN HEALTH ASSESSMENT CENTER FOR ATHLETES
AUTORIZATION TO DISCLOSE HEALTH INFORMATION

PATIENT NAME: a a DOB: 02/03/2001

ADDRESS: 9 Belleville Avenue Bloomfield, New Jersey 07003

TELEPHONE: (234)234-2345

I hereby authorize the Matthew J. Morahan Health assessment Center for Athletes ("MJM Center"), and Barnabas Health to disclose the Patient's health information described below to:

PEDIATRICIAN: Richard King

PATIENT'S TEAM and/or SCHOOL STAFF OR REPRESENTATIVE: Tom Thomas (Athletic Trainer)/Jeffrey Radigan (Supervisor), Dr. Gingerelli (School Physician)/Vanessa Nowinski (School Nurse)

ADDRESS AND/OR FAX NUMBER OF RECIPIENT (REQUIRED): 1 Congers Road Congers, New Jersey 09876

The Health Information described below is being disclosed for the following purpose:
To assess the Patient's ability to participate in sports activities and for related team and school purposes.

Information to be disclosed:
Results of all Cardiac Screenings, all Baseline Concussion Screenings and all Post Injury Concussion Testing on the Patient named above, which screening and/or testing were performed by, or sent to the MJM Center, and/or performed by or sent to Barnabas Health, during any dates before or after this form is signed.

This authorization will expire **four (4) years from the date of my signature below,** unless I otherwise specify that this authorization will terminate on the following date:_____

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to the MJM Center Director. I understand that this revocation will not apply to the extent that Barnabas Health and the MJM Center have already released my information in reliance on this authorization.

I understand that this disclosure of my health information is voluntary. I ca refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for treatment, enrollment or eligibility for health benefits, but I understand that in some cases, my school may not pay for tests performed by the MJM Center unless I release the results to the school. I understand that once my information has been disclosed to the school or team named above, health care provider privacy laws may no longer apply, and any disclosure of information carries with it the potential for un-authorized re-disclosure by the recipient. If I have questions about the disclosure of my health information under this form, I can contact the MJM Center Director.

PATIENT SIGNATURE:  Date: 10/10/2014

If legal representative (e.g., parent or guardian of a minor), is signing below, please state relationship and authority to sign on behalf of patient.

SIGNATURE OF LEGAL REPRESENTATIVE/PARENT/GUARDIAN: 

PRINT NAME OF LEGAL REPRESENTATIVE/PARENT/GUARDIAN: Forest Becker DATE: 10/10/2014
RELATIONSHIP OF REPRESENTATIVE TO PATIENT: Father

PATIENT (OR REPRESENTATIVE OF MINOR) MUST BE GIVEN A COPY OF THE AUTHORIZATION FORM