Ochsner Rush Health

Ochsner Rush Health Athletic Physical Screening

1314 19th Ave. Meridian, MS 39301

Name_____

Grade_____

School _____

Male / Female Date of Birth:_____

DO NOT FOLD OR BEND THIS FORM.

Medical History of Injuries

Have you ever experienced: (check if yes)

1. Concussion ____
2. Neck or Back Injury ____
3. Shoulder Injury ____
4. Elbow Injury ____
5. Arm, Wrist, Hand Injury ____
6. Rib(s) Injury ____
7. Hip Injury ____
8. Thigh Injury ____
9. Knee Injury ____
10. Ankle Injury ____
11. Foot Injury ____

Questions about your health

Do you experience or have you experienced: (check if yes)

1. Frequent Headaches ____
2. Fainting Spells ____
3. High Blood Pressure ____
4. Difficulty Breathing ____
5. Allergic Reaction ____
6. Irregular Heartbeats ____
7. Chest Pain ____
8. Abnormal Bleeding ____
9. Vision Difficulties ____
10. Asthma ____

Questions Concerning Your Medical History (answer yes or no)

1. Are you currently taking any prescription medications? ____ , if yes, please list _____
2. Are you allergic to anything?____, if yes, please list_____
3. Have you ever experienced any heat-related illness?_____
4. Are you missing any organs? Y___or N___ If so explain _____

Personal Information

Physician's Name, Dr. _____ Parent's Name_____

Home Telephone Number _____ Parent's Work Number _____

Emergency Number_____

As the guardian of this athlete (if under 18), I understand that this physician examination is a limited examination and does not prevent any injury, serious illness, or death.

Medical Waiver Form

This waiver, executed this date by any physician or medical professional involved with this physical screening is executed in compliance with Mississippi law, which provides if a physician voluntarily provides needed medical or health services to any program at an accredited school in the state without expectation of payment, the physician will be immune from liability for any civil action arising out of the provision of those medical and/or health care services which were provided in good faith on a charitable basis. Such immunity does not extend to acts of willful or gross negligence.

I give permission to the doctor treating my child, in the event of an injury, to discuss his/her/condition with the athletic trainer involved in the medical care and/or rehabilitation program.

Signature (Guardian must sign if under 18.) _____

INVALID IF NOT SIGNED BY PARENT OR GUARDIAN

DO NOT WRITE BELOW THIS LINE; TO BE COMPLETED BY MEDICAL PERSONNEL ONLY!

Height_____ Weight_____ BP_____ / _____ Pulse _____ Vision Test: Pass Fail Corrected Uncorrected

Orthopedic Exam	OK	Further Eval
Neck	___	___
Shoulder	___	___
Elbow	___	___
Hand	___	___
Wrist	___	___
Back	___	___
Knee	___	___
Ankle	___	___
Feet	___	___
Hip	___	___
Dental Exam (if available)	___	___

Medical Exam	OK	Further Eval
Heart Rhythm	___	___
Lungs	___	___

Other Conditions: _____

_____

_____

_____

___ This athlete shows no medical findings at this time and should be allowed to participate in athletic competition.

___ This athlete should have further evaluation before participating in any athletics by the following:

Family Physician FNP Orthopedic Optometrist General Surgeon Neurologist

Internal Medicine Cardiologist ATC Other_____

Medical Professional's Signature _____ **Date**_____

NOTICE OF PRIVACY PRACTICES - SPORTS MEDICINE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Ochsner Rush Health is required by law to maintain the privacy of your medical information, to provide you with this "Notice" of its legal duties and privacy practices with respect to your medical information and to abide by the terms of this "Notice." This "Notice" applies only to participants in Ochsner Rush Health's Sports Medicine program. A separate notice will be provided if you become a patient at Ochsner Rush Health or any of its affiliated entities. Ochsner Rush Health has an Organized Healthcare Arrangement (OHCA) with its medical staff. When using protected health information (PHI) obtained for treatment of a patient at the hospital and for payment of these services, medial staff physicians will follow the Ochsner Rush Health privacy practices. At their private offices, they will follow their own privacy practices.

HOW YOUR MEDICAL INFORMATION WILL BE USED AND DISCLOSED: We will use your PHI as part of rendering patient care. For example, your PHI may be used by the doctor or nurse treating you, by the business office to process your payment for the services rendered, and by administrative personnel in order to review the quality of the care you received. We may also use your PHI in accordance with federal and state laws for the following purposes:

- Appointment Reminders: We may contact you to provide appointment reminders .
- Treatment Information: We may contact you with information about treatment alternatives and other health-related benefits and services.
- Disclosure to Department of Health and Human Services: We may disclose your PHI when required by the United States Department of Health and Human Services as part of an investigation or determination of our compliance with relevant laws.
- Public Health and Health Oversight Activities: We may use or disclose your PHI (1) for public health activities, including the reporting of disease, injury, vital events, and the conduct of public health surveillance, investigation, and/or intervention, or (2) to a health oversight agency for oversight activities authorized by law, including audits, investigations, inspections, licensure, or disciplinary actions, administrative, and/or legal proceedings.
- Abuse or Neglect: We may disclose your PHI when it concerns abuse, neglect, or violence to you in accordance with federal and state law.
- Legal Proceedings: We may disclose your PHI in the course of certain judicial or administrative proceedings.
- Law Enforcement: We may disclose your PHI for law enforcement purposes or other specialized government functions.
- Public Safety: We may use or disclose your PHI to prevent or lesson a serious threat to the health or safety of another person or to the public.
- Family and Friends: Unless you object, we may disclose your PHI to a family member or close personal friend if the PHI is relevant to that person's involvement with your care.
- Business Associates: We may disclose your PHI to a business associate with whom we contract to provide services on our behalf. We require our business associates to appropriately safeguard our patient's PHI.

AUTHORIZATIONS: We will not use or disclose your PHI for any other purpose without your written authorization except as otherwise permitted or required by law. Once given, you may revoke you authorization in writing at any time except to the extent that Rush has taken action in reliance on the use or disclosure as indicated in the authorization. To request a Revocation of Authorization form, you may contact: CORPORATE, 1314 19TH AVENUE, MERIDIAN, MISSISSIPPI 39301, 601-703-9100.

YOUR RIGHTS REGARDING YOUR MEDICAL INFORMATION: You have the following rights with respect to your PHI:

- You may ask us to restrict certain use and disclosures of your PHI. We are not required to agree to your request, but if we do, we will honor it.
- You have the right to receive communications from us in a confidential manner.
- Generally, you may inspect and copy your PHI, subject to certain specific exceptions, and may be charged a reasonable copy fee.
- You may ask us to amend your PHI. We may deny your request for certain specific reasons and will provide you with a written explanation for the denial and information regarding further rights you may have at that point.
- You have the right to receive an accounting of disclosures of your PHI made by Ochsner Rush Health during the last six years (or following April 14, 2003). The right to receive this information is subject to certain exceptions, restrictions, and limitations.
- You may request a paper copy of this "Notice of Privacy Practices."
- You have the right to complain to us and/or to the United States Department of Health and Human Services if you believe that we have violated your privacy rights. If you choose to file a complaint, you will not be retaliated against in any way. To complain to us or obtain further information regarding your rights or regarding the use and disclosures of your PHI, please contact: CORPORATE COMPLIANCE, 1314 19th AVENUE, MERIDIAN, MISSISSIPPI 39301, 601-703 -9100.

REVISION OF NOTICE OF PRIVACY PRACTICES: We reserve the right to change the terms of this "Notice," making any revision applicable to all the protected health information we maintain. If we revise the terms of this "Notice," we will post a revised notice at Rush facilities and will make paper copies of the revised Notice of Privacy available upon request.

THIS NOTICE IS EFFECTIVE AS OF (Date).