

Durham Public Schools

Assumptions of Risk/Medical Treatment Release

Student – Athlete Name _____

School _____

Sport(s) _____ Date _____

The Durham Public Schools system makes every effort to prevent injuries, but injuries do occur in athletics.

By signing below, I understand:

1. The Rules and procedures of the sport listed above and am aware of the risks involved in playing them
2. The necessity of using the proper techniques and protective equipment (when needed).

I recognize that there are inherent risks in all athletic events (head and spinal cord injuries, fractures, internal injuries, etc.) and herby give my permission for my son/daughter to participate in any and all interscholastic events sponsored by Durham Public Schools.

Permission is herby granted to Durham Public Schools and it's authorized reprehensive to initiate treatment and rehabilitation of injuries and authorize any needed major medical or minor surgical treatment, x-ray, examination, and immunization of the above named participating by appropriate medical personnel. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that every attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above name individual may be given.

I herby release the Durham Public Schools system, local/individual school personnel, and the individual members of each athletic department including, but not limited to, its coaches, certified athletic trainers, student athletic trainers, athletic training student aides, administrators, attending physicians, and all other connected with school athletic activities, from any and all damages for injuries sustained by my son/daughter while participating in any sports activity associated with Durham Public Schools and do herby agree to hold harmless any and all the above from any and all damages which they may suffer as a result of injuries sustained by my son/daughter while participating as above stated.

Are you presently taking any medications, supplements, or pills? Yes ___ No ___

If yes, please list: _____

Does student named above have allergies? Yes ___ No ___

(medicines, bee stings, hay fever, etc)

If yes, please list: _____

Phone # Primary _____ Secondary _____

Cell _____

Emergency Contact: Name _____

Primary # _____ Secondary _____

Signature: (Parent/Guardian): _____ Date _____

Durham Public Schools Medical Examination Form

Athlete's Name: _____ Date of Birth: _____

Height _____ Weight _____ Blood Pressure _____/_____/_____ Pulse _____

Vision: Right 20/____ Left 20/____ Corrected: Yes No School _____

	Normal	Abnormal Findings
Cardiovascular		
Pulses		
Heart		
Lungs		
Skin		
ENT		
Abdominal		
Genitalia (Males)		
Musculoskeletal		
Neck		
Shoulder		
Elbow		
Wrist		
Hand		
Back		
Knee		
Ankle		
Foot		
Other		

The following conditions are automatically considered disqualifying until medical and parental releases are obtained:
 Acute infection, obvious growth retardation, diabetes, jaundice, severe visual and auditory impairment, pulmonary insufficiency, organic heart disease or hypertension, enlarged liver or spleen, hernia, musculoskeletal deformity with a function loss, history, history of convulsions or concussions, absence of one kidney, eye or testicle. This list is not intended to include all disqualifying conditions.

I certify that I have examined the above named student and that such examination reveals _____ conditions/ _____
 No conditions that would prevent this student from participating in the interscholastic sports listed.

If the student is disqualified, list reasons: _____

Physicians Signature: _____ License # _____ Date _____

Address: _____ Phone: _____

Please Read the Following Form Carefully

**Authorization For Release of Protected Health Information For Athletic Participating
In Durham Public Schools Athletics Program**

Once properly signed, this authorization will allow for the release of protected health information to the Durham Public Schools Systems (DPS) by physicians and health care providers (Providers) rendering services to DPS athletes. The purpose of the release of the protected health information is to allow the DPS Athletic Program to determine the advisability of an athlete's participation in DPS athletics. An example would be the release of a screening physical examination.

By signing this Authorization for my son, daughter or other person for whom I have legal authority to act (hereinafter referred to as "Athlete"), I hereby authorize health care providers (including, but not limited to, the Duke University Sports Medicine Program and its physicians and providers) that are contracted with DPS to release to each other and to the DPS oral and written medical information relating to the Athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of DPS Athletic Program. The medical information should be used by the DPS Athletic Program for the purpose of determining the advisability of the Athlete's participation in DPS athletics.

This authorization is expressly bound by all the following conditions:

This Authorization will automatically expire upon the Athlete's termination of participation or ineligibility in DPS Athletics, except to the extent relied upon for disclosures made prior to the automatic expiration.

This Authorization may be revoked at any time, provided the revocation *is a properly executed written document and delivered to the Director of Athletics for Durham Public Schools*. As soon as practicable, DPS shall inform each contracted health care provider prior of each Athlete's revocation. However, any such revocation shall not affect disclosures made by a health care provider prior to that health care provider's receipt of the revocation for DPS. In addition, such revocation shall not affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such affect disclosures made prior to the receipt of the revocation to the extent that this Authorization was relied upon for such disclosures.

This Authorization is not intended to alter the Athlete's ability to receive medical care from any health care provider regardless of whether this Authorization is agreed to or refused.

This Authorization shall cover actions by and for Duke University, Duke University Health System, Inc. and Private Diagnostic Clinic, PLLC, and all of their respective employees, workforce, and business associates, and all other physicians and health care providers contracted with DPS and their respective employees, workforce, and business associates. For a complete list of contracted health care providers for DPS that may release medical information pursuant to the Authorization, please contact Durham Public Schools.

The athlete and Parent/Guardian will receive a complete copy of the signed Authorization.

A copy of this Authorization and any revocation of it will be kept by both the Duke Sports Medicine Office, Durham Public Schools and other health care providers contracted with Durham Public Schools.

Protected health information released by the health care providers to Durham Public Schools is not protected by this Authorization from re-disclosure by Durham Public Schools.

Date: _____

Parent/Guardian Signature

Printed Name Relationship to Athlete

Athlete's Name - Printed

**This Authorization (and any revocation) must be signed by a parent, guardian, or other person acting in loco parents who has the authority to act on the Athlete's behalf. By signing this form, you as the parent/guardian or party acting in loco parents warrant that you have the legal authority to act on the Athlete's behalf.

**The signature may be only the Athlete if the Athlete is over 18 years of age or legally emancipated person.