

Athletic Training Services
Doral Academy Preparatory School
In Affiliation with The Orthopaedic Institute at Jackson

Emergency Contact Information

Name _____ Gender M / F Birth date ___ / ___ / ___
Mother's Name _____ Father's Name _____
Home Address _____ Home Telephone (___) ___ - _____

Person to Contact in the case of an Emergency _____
Telephone (___) ___ - _____

Mother's Daytime Contact/Cellular Telephone (___) ___ - _____
Father's Daytime Contact/Cellular Telephone (___) ___ - _____

Physician Information

Doctor's Name _____ Telephone (___) ___ - _____
Hospital _____

Allergies _____ Medications _____

(Please include all medications including dietary supplements.)

Insurance Information

Primary Insurance Name _____
Policy Number _____ Telephone (___) ___ - _____

Permission to Treat

I give my permission for the Certified Athletic Trainer and/or Team Physician to treat my child in the case of an athletic injury incurred as a participant at Doral Academy Preparatory School.

Yes _____ No _____

I give my permission for coaches to provide First Aid until the Athletic Trainer, Team Physician, and/or Family Physician can be contacted.

Yes _____ No _____

I give consent for coaches, athletic trainers, and team physicians to use their best judgment in securing medical aid and ambulance service in the case that the parents/guardians cannot be reached.

Yes _____ No _____

Parent's Signature _____
Date _____

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Authorization for Release of Medical Record Information

I have received the **Notice of Privacy Practices** (attached) and I hereby authorize the physicians, athletic trainers, sports medicine staff and other health care personnel representing Doral Academy Preparatory School and The Orthopaedic Institute at Jackson to release information regarding the student-athlete's protected health information and related information regarding any injury or illness during the student-athlete's training for and participation in athletics at Doral Academy Preparatory School. I further understand that it is my choice to comply with the requirements of his/her school and the release of protected health information to a coach, athletic director, or school official in connection with participation in interscholastic sports. This protected health information may concern the student-athlete's medical status, medical condition, injuries, prognosis, diagnosis, athletic participation status, and related personally identifiable health information. This protected health information may be released to other health care providers, hospital and/or medical clinics and laboratories, athletic coaches, medical insurance coordinators, athletic and/or school administrators, chaplains and/or clergy members, officials of the Miami-Dade County School District and the Miami-Dade County Athletic Association.

I _____, parent/guardian of _____
(parent/legal guardian) (student-athlete)

understand that as a parent/legal guardian give authorization for the disclosure of the student-athlete's protected health information. I understand that my protected health information is protected by the federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either parent/legal guardian authorization under HIPAA or consent under the Buckley Amendment. I, the parent/legal guardian, understand that I may revoke this authorization at any time by notifying in writing to the school's athletic director, but if I do, it will not have any effect on the actions of those representing Doral Academy Preparatory School and The Orthopaedic Institute at Jackson prior to receiving the revocation. This authorization expires one year after the dated signature.

This form is required in order for the medical staff to share pertinent medical information with the appropriate authorities and individuals. The disclosure of medical information will be at the discretion of the Athletic Trainer and the Team Physician who are held to the highest ethical standards.

Student-Athlete (Print)

Signature of Parent/Legal Guardian

Date

Date

Please check all individuals with whom I may disclose health information:

- Athletic Director School Administrators Head/Position Coach
 School Nurse Other _____
-
-

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Notice of Privacy Practices 8/28/09

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. If you have any questions, please contact our Risk Management Office at the address or telephone number at the bottom of this Notice.

This Notice of Privacy Practices provides health care to our patients in partnership with physicians and other professionals and organizations. The information privacy practices in this Notice will be followed by all departments and units of our organization, including all off-campus units or departments, and all employed associates, staff or volunteers of our organization.

In addition, we are a clinically integrated care setting, and we have many Athletic Trainers and other providers giving care to patients at our Affiliated Clinical sites. For convenience of our patients, we are giving one Notice of Privacy Practices to each patient, instead of notices from multiple physicians and other caregivers. This Notice serves as the notice required under Federal law to be given to patients by this school, and all members of our medical staff or all other health care professionals who treat you at any of our locations. The health care providers covered by this "organized health care arrangement" ("OHCA") will share protected health information with each other, as necessary to carry out your treatment, payment for treatment, and health care operations relating to the OHCA. This arrangement does not mean that the persons participating in the OHCA are involved in a joint business arrangement, or that they are responsible for the acts of one another.

Our pledge to you as a patient. You have the right to privacy concerning your medical plan of care. Medical record information and your relationship with your physical are considered private. Your diagnosis and course of treatment are available only to those directly involved with your care. Unless you tell us otherwise, we will make every effort to give your family continuous updates on your condition. We create a record of the care and services you receive to provide quality care and to comply with legal requirements. This Notice applies to all of the records of your care that we maintain, whether created by facility staff or your doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your medical information created in the doctor's office. We are required by law to:

- Keep medical information about you private- .Give you this Notice of our legal duties and privacy practices with respect to medical information about you.
- Follow the terms of the Notice that is currently in effect.

Changes to this Notice. We reserve the right change the terms of this Notice at any time. Changes will apply to medical information we already hold, as well as new information we receive after the change occurs. If we change our Notice, we will post the new Notice in the athletic training room. You can receive a copy of the current Notice at any time. The effective date is listed just below the title above. You will be offered a copy of the current Notice each time you register at a facility for treatment. You will also be asked to acknowledge in writing your receipt of this Notice on our General Consent for Treatment form.

How we may use and disclose medical information about you. We may use and disclose medical information about you for treatment (such as sending medical information about you to a specialist as part as a referral); to obtain payment for treatment (such as sending billing information to your insurance company or Medicare); and to support our health care operations (such as comparing patient data to improve treatment methods). We may disclose medical information to "business associates" who provide contracted services such as accounting, legal representation, claims processing, accreditation, and consulting. If we do disclose medical information to a business associate, we will do so subject to a contract that provides that the information will be kept confidential, within the timeframes required by HIPAA of 1996.

We may use or disclose information about you without your prior authorization for several other reasons. Subject to certain requirements, we may give out medical information about you without prior authorization for public health purposes (such as reports of communicable diseases).
