Licking Memorial Health Systems
Sports Screening Program Consent

Student name: _____ **Date of birth:** _____

Parent or guardian name: _____ **Contact phone #:** _____

Address: _____ **City:** _____ **Zip:** _____

School district: _____ **School:** _____ **Grade:** _____
(next school year)

Primary care physician: _____
First name Last name Phone number

Address: _____ **City:** _____ **Zip:** _____

Services/tests that may be performed according to program guidelines, include:

- Pre-participation Physical Evaluation
- Electrocardiogram (EKG)
- Echocardiogram
- ImPACT Testing

I understand that by signing this form, I am consenting to the above referenced services/tests as a component of the Licking Memorial Health Systems (LMHS) Sports Screening Program which also meets the standards of the OHSAA pre-participation evaluation requirements. Components of the Sports Screening Program – including the pre-participation physical evaluation, EKG, Echocardiogram and/or ImPACT Concussion Screening – will not diagnose all present or future health or cardiac conditions. Any change in symptoms or physical finding should be reported to the athlete's primary care physician, athletic director or coach immediately.

Authorization to Release Information

I also understand that by signing this consent, it allows LMHS to release the results of the evaluation and/or testing to the student's primary care physician. Abnormal test results or findings outside of the expected normal range will be referred back to the student's primary care physician for further evaluation. The athletic director or athletic personnel at the school will be notified in the event of abnormal results that would prevent the student from participating in any strenuous or athletic event, until cleared by their primary care physician.

The purpose of these disclosures is to notify the student's primary care physician and/or school of the test results from the Sports Screening Program. This authorization shall not expire unless revoked. The authorization may be revoked by contacting the Program Coordinator at (220) 564-2304. These screenings are solely for the purpose of providing the results to the student's primary care physician and/or school; therefore, this consent and authorization to release the information is required as a condition to participate in the Sports Screening Program.

Episodic Care

I have been advised and understand that participation in the LMHS Sports Screening Program, including any testing provided during the program, does not establish an ongoing care relationship with the provider. I understand the program is considered episodic care and does not create a physician-patient relationship.

Student signature: _____ **Date:** _____

Parent/guardian signature: _____ **Date:** _____

7487-5001
04/09/2021