

Printed Name _____

Home Phone _____

Cell Phone _____

Medical History

*Please fill in the information below as completely as possible. Any treatment for injury/accident may be based solely on the information given. Have you had (or presently have) any of the conditions listed below? Please give additional information as needed.

	(Circle one)		Additional Information
Heart Disease/Problems	Yes	No	_____
Respiratory Problems	Yes	No	_____
Asthma	Yes	No	_____
Diabetes	Yes	No	_____
How controlled: Diet	Insulin injection		Insulin pump
Hypoglycemia	Yes	No	_____
Seizures	Yes	No	_____
Type: _____	Duration: _____		Protocol: _____
High Blood Pressure	Yes	No	_____
Hepatitis	Yes	No	_____
Kidney Disease	Yes	No	_____
Hernia	Yes	No	_____
Tuberculosis	Yes	No	_____
Stroke	Yes	No	_____
Cancer	Yes	No	_____
Mental/Nervous Disorder	Yes	No	_____
Spinal/Neck Injuries/Problems	Yes	No	_____
Type/level: _____			
Joint Injuries/Problems	Yes	No	_____
Head Injury.....	Yes	No	_____
Type: _____			
Fainting Spells	Yes	No	_____
Vision Problems	Yes	No	_____
Hearing Problems	Yes	No	_____
Amputation	Yes	No	_____
Prosthetics/Prosthesis	Yes	No	_____
Medication Allergies	Yes	No	_____
Other Allergies	Yes	No	_____
Implanted Medical Devices/Pins/Plates	Yes	No	_____
Any other medical condition/diagnosis we should be aware of? _____			

Have you had a recent tetanus booster? _____ If so, when? _____

Has a doctor placed any restrictions on your activity? _____

Please list all medications you are currently taking, including dosages:

Updates:	Date	Initials	Date	Initials
	_____	_____	_____	_____
	_____	_____	_____	_____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Statement of Intent: It is my understanding that Congress passed a law entitled the Health Insurance Portability and Accountability Act (“HIPAA”), and that there are comparable Colorado state laws, that may limit the use, disclosure or release of my health information (herein “protected medical information”). I am signing this Authorization because it is crucial that my health care providers readily have access to and use my protected medical information to allow them to discuss with, and obtain advice from, those persons designated in this Authorization to facilitate decisions regarding my health care when I otherwise may not be able to do so (without regard to whether any health care provider has certified in writing that I am incompetent for purposes of HIPAA or Colorado state law):

1. **Grant of Authority.** I hereby authorize any member of the board of directors of Colorado Springs Sled Hockey Association (“CSSHA”), to use, release and disclose my protected medical information, including my Medical History Questionnaire (attached), in the event I am injured or unable to explain my condition to medical care professionals or to a medical care treatment facility.
2. **Termination/Revocation.** This Authorization is not affected by, and shall not terminate by reason of, my subsequent disability or incapacity. This Authorization shall terminate upon my written revocation expressly referring to this Authorization actually received by CSSHA, effective as of the date of said receipt by CSSHA.
3. **My Waiver and Release.** With regard to any protected medical information disclosed pursuant to this Authorization, I waive any right of privacy that I may have under the authority of the HIPAA, any amendment or successor to that Act, or any similar state or federal act, rule or regulation. In addition, I hereby release any medical care professional, medical care treatment facility, CSSHA, and members of the board of directors of CSSHA from any liability that may accrue (i) from the use or disclosure of my protected medical information and (ii) from any other actions taken by or on behalf of CSSHA; or by members of the CSSHA Board of Directors, on my behalf.
4. **Copies/Severability.** CSSHA may make photocopies of this Authorization and each photocopy will have the same force and effect as the original (photocopies shall include: facsimiles and digital or other reproductions, hereafter referred to collectively as “photocopy”). In the event that any provision of this document is invalid, the remaining provisions shall nonetheless remain in full force and effect.

I understand that I have the right to receive a copy of this Authorization. I also understand that I have the right to revoke this Authorization and that any revocation of this Authorization must be in writing.

Date: _____

Player’s Signature

Printed Name

Parent’s signature (for minors)

Printed Name