ST.ANTHONY HIGH SCHOOL
REQUIRED IHSA & HSHS CONSENT FORM FOR ALL ATHLETES

IHSA Sports Medicine Acknowledgement & Consent Form Acknowledgement and Consent Student/Parent Consent and Acknowledgements By signing this form, we acknowledge we have been provided information regarding concussions and the IHSA Performance-Enhancing Substance Policy. Link—https://www.ihsa.org/documents/sportsMedicine/current/Sports%20Medicine%20Consent%20and%20Acknowledgement.pdf

IHSA Post-concussion Consent Form (RTP/RTL) By signing below, I acknowledge the following: 1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law; 2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law; 3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), the written statement of the treating physician, athletic trainer, advanced practice nurse (APN), or physician assistant (PA) and, if any, the return-to-play and return-to-learn recommendations of the treating physician, athletic trainer, advanced practice nurse (APN), or physician assistant (PA), as the case may be. Link—https://www.ihsa.org/documents/forms/current/Post-concussion%20Consent%20Form%20(RPT-RTL).pdf

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HSHS AUTHORIZATION I hereby authorize HSHS Holy Family Hospital, Inc.; St. Anthony's Memorial Hospital, of the Hospital Sisters of the Third Order of St. Francis; St. Elizabeth's Hospital of the Hospital Sisters of the Third Order of St. Francis; St. Joseph's Hospital, of the Hospital Sisters of the Third Order of St. Francis; St. Joseph's Hospital, Breese, of the Hospital Sisters of the Third Order of St. Francis; or an affiliate of Hospital Sisters Health System, and the members of its staff (collectively, "Hospital") as follows (please check all that apply before signing the form): to release all information concerning my health care, injury, rehabilitation, treatment, and health status during my training for and participation in my school's athletics to my parents or guardians, coaches, and school personnel. I understand such information will be used to advise such persons of my health or injury status for further medical treatment and restrictions on my ability to participate in athletics. This authorization will expire six (6) years after the date below or sooner by my revocation. I understand I may revoke this authorization at any time. Revocation must be made in writing and sent to St. Joseph's Hospital, 9515 Holy Cross Lane, Breese, IL 62230, Attention: Sports Medicine. Revocation will not affect any action Hospital took in reliance on this authorization prior to revocation. I will receive no compensation for authorization for the release of this information. Hospital will not condition treatment, payment, enrollment, or eligibility for benefits on the execution of this authorization form. The information used or disclosed may be subject to redisclosure by the person or entity receiving such information and thus is no longer protected by the federal privacy regulations. I have read this authorization, fully understand its contents, and agree to be bound by its terms. I acknowledge and represent I am 18 years of age or older and have the right to contract in my own name or that I am legally authorized to sign for the student-athlete named below.

HSHS CONSENT I understand that HSHS Holy Family Hospital, Inc.; St. Anthony's Memorial Hospital, of the Hospital Sisters of the Third Order of St. Francis; St. Elizabeth's Hospital of the Hospital Sisters of the Third Order of St. Francis; St. Joseph's Hospital, of the Hospital Sisters of the Third Order of St. Francis; St. Joseph's Hospital, Breese, of the Hospital Sisters of the Third Order of St. Francis; or other affiliates of Hospital Sisters Health System (collectively, "Hospital"), when requested, from time to time, will provide staff to offer sports medicine services to the student athletes during practices, meets, and games. I understand Hospital staff are not employed, controlled, or supervised by my school. I hereby request and authorize Hospital staff to provide and perform such medical care, therapy, tests, procedures, or other services considered advisable for my health and wellbeing during my training for and participation in my school's athletics, including neurocognitive function diagnostic tests utilizing the ImPACT® Concussion TestTM, a third party computer software product licensed by ImPACT to Hospital. I acknowledge that no guarantees have been made as to the result of treatments or examinations performed by Hospital staff and that unforeseen results may occur. In the event of an injury or accident to me during participation in an athletic activity, I acknowledge that Hospital staff or school officials, as appropriate, are authorized to seek immediate medical attention, including ambulance services and assistance at the nearest medical facility. I have read this authorization, fully understand its contents, and agree to be bound by its terms. I acknowledge and represent I am 18 years of age or older and have the right to contract in my own name or that I am legally authorized to sign for the student-athlete named below.

I have read all medical information provided, IHSA sports medicine acknowledgement and consent, IHSA post-concussion consent form, HSHS concussion and consent at length and hereby agree to the above.

Student Name (Print): _____ Grade 9, 10, 11, 12

Student Signature:_____ Date:_____

Parent/Guardian (Print):_____ Date:_____

Parent/Guardian Signature:_____ Relationship to student:_____