Nemours. Alfred I. duPont Hospital for Children
Center for Sports Medicine
(302) 298 - 7200

Dear Salesianum School Parent,

Thank you for participating in Baseline Concussion Screening at the Center for Sports Medicine at A.I. duPont Hospital for Children. We are very excited to be able to work with the Salesianum School in the development and implementation of this new pre-season program. Enclosed you will find some descriptions of the baseline tests that will be performed, along with **three forms that must be completed prior to your testing day.** These three forms are essential for your son to be seen for the baseline screen:

1) "Authorization for Treatment and Release of Information"
    a. This form authorizes the sports medicine staff to see your son for the testing, if you would like to review the Notice of Privacy Practices, please see www.nemours.org for the full policy.
    b. Please fill in name, and sign bottom, staff will fill in MR# section.
2) "Authorization to Use/Disclose Protested Health Information"
    a. This form states that you would like the results sent to you
    b. Please fill in your son's info under "Patient name" and "Date of Birth" name and address in the "Disclose Medical Records To:" section and sign bottom, staff will fill in MR# section.
3) "Patient Presents for Appointment without Legal Guardian"
    a. By filling out this form, you are authorizing your son to be seen for the baseline screen without you present.
    b. Please fill in name, and sign bottom, staff will fill in MR# section.

The night before testing, we advise getting a good night sleep. Please arrive for you appointment at your scheduled time. Please dress as you would for a workout (sneakers, tee shirt, shorts/sweatpants). You can enter the building at the main entrance (playground in front) and follow directions to the ground floor, Center for Sports Medicine where testing will take place. **Please bring all completed forms in this registration packet** with you to hand in at the desk. **Payment of $55 will be due at that time** and can be paid in cash, check or with credit card.

Some of the test results need to be checked for validity, and so you will not receive the results at the time of testing, and so they will be sent in the mail within 2 weeks. These tests are for the purpose of obtaining a baseline measure for comparison should your son have an injury in the future; they cannot be viewed as any indicator of athletic performance or intelligence.

On the following page, you will see a brief description of the tests which will be conducted on the day of screening.

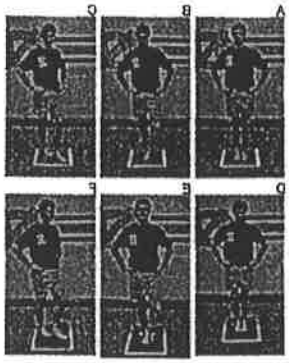
Name:_____

Appointment Date: _____

Arrival Time: _____

ImPACT testing:

*Immediate Post-Concussion Assessment and Cognitive Testing is a computerized neuro-cognitive assessment tool that measures multiple aspects of cognitive functioning in athletes
*Provides a reliable baseline to compare if a concussion occurs
*This is not an intelligence test
*Scores obtained include: Verbal memory composite, Visual memory composite, Visual Motor speed composite, Reaction time composite, Impulsion control composite & Total symptom composite score

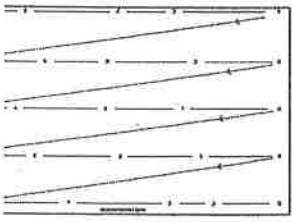


BESS test:

*Balance Error Scoring System: developed specifically for use in concussion population, as well as on the sideline
* Tests balance on firm surface and foam surface – standing two feet together, standing on one foot, standing one foot in front of the other – all with the eyes closed
*Results are variable in this age group- self comparison is helpful if a concussion occurs

NeuroCom Sensory Organization Test (SOT)

*Objective assessment of balance control and postural stability under 6 varied test Conditions
*Assesses ability make effective use of visual, vestibular and somatosensory information
*Recognized as a "gold standard" for objectively assessing balance from ages 3 to 79 years of age



King Devick Test

*Evaluation of inefficiencies regarding eye movements and tracking during reading
*Score based on speed and accuracy
*Able to be retested on sidelines or in training room for future comparison

Functional Movement Screen (FMS)

*The FMS is a grading system that documents movement patterns that are key to normal function
*Identifies functional limitations and asymmetries, issues that can reduce the effects of functional training and physical conditioning and distort body awareness
*This is not a test specific to concussion but rather gives a bigger picture of how the athlete is functioning on the field.

Nemours. Alfred I. duPont Hospital for Children
Center for Sports Medicine
(302) 298 - 7200

Dear Salesianum School Parent,

Thank you for participating in Baseline Concussion Screening at the Center for Sports Medicine at A.I. duPont Hospital for Children. We are very excited to be able to work with the Salesianum School in the development and implementation of this new pre-season program. Enclosed you will find some descriptions of the baseline tests that will be performed, along with **three forms that must be completed prior to your testing day.** These three forms are essential for your son to be seen for the baseline screen:

1) "Authorization for Treatment and Release of Information"
    a. This form authorizes the sports medicine staff to see your son for the testing, if you would like to review the Notice of Privacy Practices, please see www.nemours.org for the full policy.
    b. Please fill in name, and sign bottom, staff will fill in MR# section.
2) "Authorization to Use/Disclose Protested Health Information"
    a. This form states that you would like the results sent to you
    b. Please fill in your son's info under "Patient name" and "Date of Birth" name and address in the "Disclose Medical Records To:" section and sign bottom, staff will fill in MR# section.
3) "Patient Presents for Appointment without Legal Guardian"
    a. By filling out this form, you are authorizing your son to be seen for the baseline screen without you present.
    b. Please fill in name, and sign bottom, staff will fill in MR# section.

The night before testing, we advise getting a good night sleep. Please arrive for you appointment at your scheduled time. Please dress as you would for a workout (sneakers, tee shirt, shorts/sweatpants). You can enter the building at the main entrance (playground in front) and follow directions to the ground floor, Center for Sports Medicine where testing will take place. **Please bring all completed forms in this registration packet** with you to hand in at the desk. **Payment of $55 will be due at that time** and can be paid in cash, check or with credit card.

Some of the test results need to be checked for validity, and so you will not receive the results at the time of testing, and so they will be sent in the mail within 2 weeks. These tests are for the purpose of obtaining a baseline measure for comparison should your son have an injury in the future; they cannot be viewed as any indicator of athletic performance or intelligence.

On the following page, you will see a brief description of the tests which will be conducted on the day of screening.

Name:_____

Appointment Date: _____

Arrival Time: _____

Nemours

01016

Patient Name: _____

Patient MR#: _____

AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION FOR TREATMENT, PAYMENT & HEALTH CARE OPERATIONS PURPOSES

I have the legal authority to authorize the examination and treatment of the above patient by Nemours health care providers and associates.* I understand that the examination and treatment may include the use of x-rays, laboratory tests, medications, and other diagnostic procedures and tests normally provided in a pediatric health care environment.

I understand that information, including recordings (photographs, video, electronic or audio media), may be collected, used, and disclosed only as necessary for:

- Treatment, payment, and healthcare operations purposes,
- Public health purposes, health oversight activities, accreditation, and other activities that promote wellness; and
- Other purposes as permitted by law.

If surgery, general anesthesia, blood products, provision of psychotropic medications or other extraordinary procedures or invasive procedures are required and not emergent in nature, then this will be explained to me by the physician or physician's designee. If this occurs, I will be asked to give additional written consent.

By agreeing to receive treatment at Nemours, I acknowledge that some of my child's/ward's medical care, services and treatment may be provided by physicians and other allied healthcare providers (such as, certified registered nurse anesthetists, physician assistants, advanced registered nurse practitioners or technicians) who are not employed by Nemours. I understand these providers are responsible for the medical care, services, and treatment that they deliver.

- I authorize the examination and treatment of my child/ward.
- I acknowledge:
  - If this is my first visit to Nemours that I have received a copy of the Notice of Privacy Practices, or
  - If this is not my first visit, I am aware the Notice of Privacy Practices can be obtained from our website www.nemours.org, or from any registration, greeter, or information location.
- I consent to the collection and sharing of information as indicated above and the uses and disclosures detailed in the Nemours Notice of Privacy Practices.
- I agree that Nemours will not be responsible for the medical care, services, and treatment delivered by physicians and allied healthcare providers not employed by Nemours.
- I understand this authorization applies and extends to subsequent visits and appointments at Nemours.

I certify that I have read and understand the above statements, that all of my questions have been answered to my satisfaction, and that I agree with each statement above.

_____	_____	_____	_____ AM
Patient/Person Legally Responsible	Relationship to Patient	Date	Time PM

*Nemours includes The Nemours Foundation, its operating divisions and sites, and its affiliates and subsidiaries.

Nemours

AUTHORIZATION TO USE/DISCLOSE PROTECTED HEALTH INFORMATION

01022

Patient Name: _____ Date of Birth: _____ MR# (Staff to Complete): _____

Phone: _____ Address: _____

Email Address: _____

I would like to receive these records via ☐Fax ☐CD ☐Paper ☐Email

RELEASE MEDICAL RECORDS FROM:

Facility or Name: Nemours

Address: 1600 Rockland Rd

City/ST/Zip: Wilmington, DE 19899

Phone #: 302-651-4354 Fax: 302-651-6028

DISCLOSE MEDICAL RECORDS TO: athletic

Facility or Name: Salesianum School - Director

Address: 18th + Broom St.

City/ST/Zip: Wilm, De 19802

Phone #: 654-7736 Fax: 654-7767

I AM REQUESTING MEDICAL RECORDS FOR DATES:

FROM: _____ TO: _____ ☐ ALL

FEES: I understand and agree that there may be costs associated with this request in compliance with State and Federal Copying laws. _____ *(please initial)*

INFORMATION TO BE DISCLOSED *(please specify)*:

☐ I am requesting records from a specific department.
Department Name: _____

- ☐ Entire Inpatient Medical Record
- ☐ Entire Outpatient Medical Record
- ☐ Abstract of Medical Record
- ☐ Outpatient Clinic Note/Encounter
- ☐ Labs/Pathology Reports
- ☐ Pathology Slides/Blocks
- ☐ Imaging Reports (x-rays, MRI, etc.)
- ☐ Imaging Films
- ☐ Echocardiogram Tapes
- ☐ Operative Notes
- ☐ History/Physical Exam
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Medications
- ☐ Billing Statement
- ☐ Verbal Communication
- ☒ Other (specify below): Therapy Services

Your initials are required to release the following:

- _____ Psychiatric/Psychology Notes
- _____ Psychological Evaluations& Results
- _____ Genetics Testing
- _____ HIV Lab Reports
- _____ Drug/Alcohol Results
- _____ STD Information

Please Note: Some of these items may require signature of the minor

PURPOSE OF DISCLOSURE *(please specify)*:

☐Continuing care with another physician or hospital

☐Transfer of Care ☐Personal Copy ☐Other: _____

EXPIRATION DATE OR EVENT:

(if left blank, this Authorization expires 90 days from the date signed)

Specify a date or event: _____

AUTHORIZATION:

1. I may revoke this authorization at any time by notifying the "Sent FROM" organization noted above in writing.
2. I understand that my revocation does not affect any disclosures made prior to the revocation being received and processed.
3. I understand the information disclosed may be subject to re-disclosure and no longer be protected by federal or state privacy regulations.
4. I have the right to inspect or copy the information to be used/disclosed as permitted by federal law.
5. I may refuse to sign this authorization and that it is strictly voluntary.
6. If I do not sign this form, my health care and the payment for my health care will not be affected.
7. If this authorization originated with the provider, I will receive a copy of this form after I sign it.

Patient/Guardian/ Representative Signature: _____ Date: _____

Patient/Guardian/ Representative Printed Name: _____ Relationship to Patient: _____

Nemours

01019

Patient Name: _____

Patient MR#: _____

PATIENT PRESENTS FOR APPOINTMENT WITHOUT LEGAL GUARDIAN AUTHORIZATION FOR TREATMENT FORM

Quality health care requires a team approach between the parent/legal guardian and your child's health care provider. Nemours encourages the parent/legal guardian to be present with their child at all visits. The presence of the parent/legal guardian ensures good two-way communication to make certain your child's health care needs are understood and addressed. Nemours understands, however, that occasionally minor children live with and/or are well cared for by members of their extended families or others. As a result, on occasion a minor requiring treatment will not be accompanied by the parent/legal guardian, and efforts by Nemours to communicate with the minor's parent/legal guardian at the time of the visit may not be desired by the parent/legal guardian.

I represent that I am the parent/legal guardian and have the legal authority to authorize the examination and treatment of: _____ by Nemours health care providers and associates. I understand that the examination and treatment may include the use of x-rays, laboratory tests, photographs, medications, and other diagnostic procedures and tests normally provided in a pediatric health care clinic, but does not include consent to surgery, general anesthesia, provision of psychotropic medications or other extraordinary procedures for which a separate written informed consent as provided by law is required.

I understand and consent to Nemours making recordings (photographs, video, electronic or audio media) of my child for identification, diagnosis and treatment purposes and that these recordings may also be:

- Used within Nemours for performance improvement, medical education, and other purposes related to healthcare operations provided my child's identity is revealed only when necessary to complete the task.
- Disclosed to individuals external to Nemours only if my child's identity has been completely removed from the recording, or if Nemours has a written authorization from me, my child's legal representative, or my child upon reaching the age of majority (adulthood).

I authorize the examination and treatment of my child listed above by Nemours. I understand that this authorization applies and extends to subsequent visits and appointments at Nemours, even if my child is not accompanied by me, and is valid for one year.

I understand it is my obligation to know when my child is examined and treated at Nemours, to know who accompanied my child to the visit, if anyone, and to take steps promptly following the visit to make sure I understand the recommendations and plans instituted by Nemours to address my child's health needs. I understand the recommendations and plans instituted by Nemours to address my child's health needs will be shared with the person who accompanied my child to the visit, and that I may obtain the recommendations and plans from that person or by communicating with the Nemours provider who examined and treated my child.

_____ _____

Print Name Signature

_____ _____

Date Relationship to Patient

*Nemours includes The Nemours Foundation, its operating divisions and sites, and its affiliates and subsidiaries.