



**USA DEAF SOCCER ASSOCIATION**

3575 FAR WEST BLVD., P.O. BOX 28253  
AUSTIN, TX 78731

## **USADSA Consent Forms for Minors**

## USADSA Medicine Program Consent for Medical Care and Treatment

I, the parent/legal guardian of a minor USADSA event athlete, authorize USADSA, and each of its affiliated, participating parties as applicable, and associated staff (collectively referred to as "USA Med") to provide my child such healthcare, treatment, or other services and, where appropriate, to make referrals for my child to receive additional health services that my child's condition may indicate. *In any such event, athletes and their parents/legal guardians shall have the option to choose any medical provider as they and/or their legal guardian(s) may choose, as many options are available to athletes. No athlete and/or his or her parents/guardians are required to utilize USA Med for medical services.*

**Pre-Participation Physical.** I hereby give my consent/permission to USA Med and participating, licensed or other medical providers to perform a pre-participation screening physical examination ("screening exam") for my child. I agree that this screening exam is only a limited, screening examination and does not take the place of a complete medical examination. I understand and agree that the medical provider(s) completing the screening exam shall not be responsible for any ongoing medical care or treatment for any medical condition or for injuries that occur after the screening exam. I represent, to the best of my knowledge, that my child has no known medical condition that would prevent participation in sports. I agree to follow up with my child's primary care provider in the event that any medical condition is identified in the screening exam.

**Injury and/or Emergency Treatment:** In the event that it becomes necessary, I agree that the team physician or athletic trainer, as appropriate, may provide medical care and/or treatment to my child as provided herein for a sports-related injury. In addition, in the event my child needs urgent or emergency treatment, I authorize the staff of USA Med, where appropriate, to arrange for such care with appropriate providers, including appropriate transportation. In such instance, I authorize USA Med, where appropriate, to undertake any acts which may be necessary or proper to provide for the health care of the minor child named herein, including, but not limited to, the power (i) to provide for such health care at any hospital or other institution, or the employing of any physician, dentist, nurse, or other person whose services may be needed for such health care, and (ii) to consent to and authorize any healthcare, including administration of anesthesia, X-ray examination, performance of operations, and other procedures by physicians, dentists, and other medical personnel except the withholding or withdrawal of life sustaining procedures. By signing below, I indicate that I have the understanding and capacity to communicate health care decisions on behalf of the child named herein and that I understand the contents of this document. I understand that the USA Med staff, as appropriate, will contact me as soon as possible in the event my child has an urgent or emergency condition.

**Payment for Services Rendered.** I understand that I will not be charged by USA Med for services rendered on-site by the USA Med Athletic Trainer or other USA Med Sports Medicine staff assigned, but that I or my insurance carrier may be charged for services rendered by other healthcare providers for follow-up care or treatment.

**Health Information.** I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the USADSA events and as required for medical care and treatment or other services provided by USA Med. I understand that I may contact the USA Med Athletic Trainer or the assigned Team Physician to discuss my child's care or to discuss any questions that I may have about the program.

**Neurocognitive Testing.** I understand and agree that my child may undergo a computerized concussion evaluation system, such as ImPACT, as part of an overall concussion management protocol. <https://www.impacttest.com/about>

**Athletes.** I understand and agree that USA Med may be involved in the education of student athletic trainers (at the college level and student aides at the high school level), physicians, nurses, technicians and other health care providers, interns, volunteers, and observers. I understand and agree that these individuals may participate as is appropriate in providing athletic training, medical care and/or treatment to my child as provided herein for a sports-related injury or otherwise.

**Medication.** Athletic Trainers are not responsible for an athlete's prescription or non-prescription medication(s). An athletic trainer may, under the supervision and protocol of a provider, receive, store, and administer medication to my child and/or store my child's medication for the duration of an athletic event upon my request.

---

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE AND CONSENT TO MY CHILD'S PARTICIPATION IN THE USA MED SPORTS MEDICINE PROGRAM AND TO THE OTHER TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.**

**AUTHORIZATION FOR ACCESS, USE, OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, the parent/legal guardian of a minor USADSA event athlete, authorize USADSA, and each of its affiliated, participating parties as applicable, and associated staff (collectively referred to as "USA Med") consent to and authorize the release by USA Med of information about my child's medical condition obtained. I also specifically consent to and authorize the sharing of my child's medical information among the USA Med staff (team physicians, if any, other medical staff/providers, athletic trainers, and any athlete assistants) and the USADSA athletic staff, managers/coaches, and administration.

**I understand and agree to the following:**

1. This authorization for the release of my health information is voluntary, which means I do not have to authorize this release or sign this form.
2. As applicable, this release may include information related to behavioral/mental health, drug and alcohol abuse treatment, genetic information, HIV/AIDS, and other sexually transmitted diseases, unless limited by the above selections.
3. My decision to sign this authorization will not have an effect on the treatment provided to my child by any applicable health care provider, the cost of that treatment, or any benefits.
4. I may revoke this authorization at any time by notifying USADSA in writing.
5. Revoking this authorization will not affect any disclosures made prior to revoking this authorization.
6. Unless revoked this authorization will extend until the end of the calendar year 2021.
7. After release my information may no longer be protected by privacy regulations, which means the person receiving may be able to share that information without my permission.
8. USA Med will not use or share my health information without my permission, except as allowed or required by law.
9. This form will not be used for marketing or research.
10. A fee may be charged for providing any requested medical records.
11. I may ask for and get a copy of this authorization. A readable photocopy/fax of this authorization shall have the same force and effect as the original.

I hereby authorize the access, use or disclosure of my child's health information as described in this form.

**I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO THE TERMS AND CONDITIONS CONTAINED HEREIN. I HEREBY CERTIFY THAT I AM THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED HEREIN.**

# Medication Agent Form

*This form must be completed if you authorize the Athletic Trainer to administer prescribed medications to your child as needed for conditions such as allergies (epi pen), diabetes (insulin), or asthma (inhaler).*

I, \_\_\_\_\_, the parent/legal guardian of \_\_\_\_\_, an athlete participating in a USADSA event, whose date of birth is \_\_\_\_\_, authorize USADSA, and each of its affiliated, participating parties as applicable, and associated staff (collectively referred to as "USA Med") and their respective staff, as applicable, under the supervision and protocol of a physician, to receive, store, and administer indicated medication, which is prescribed in my child's name.

The medication is: \_\_\_\_\_

I authorize the release of any information pertaining to my listed medications to USA Med.

**Printed Athlete's Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Medication(s) Prescribed:** \_\_\_\_\_

**Prescribing Physician Name, Address, and Phone Number:**

\_\_\_\_\_

**Condition requiring Prescription:** \_\_\_\_\_

**Dosage and Administration Instructions:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_  
Name of Parent/Legal Guardian (please print)

\_\_\_\_\_  
Relationship to Athlete

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Date

**FORM MUST BE COMPLETED AND EMAILED TO APPROPRIATE AUTHORIZED USADSA STAFF PRIOR TO PARTICIPATION. CONTACT [KWARD@USDEAFSOCCER.COM](mailto:KWARD@USDEAFSOCCER.COM) (WOMEN'S EVENT), [WFRENTZ@USDEAFSOCCER.COM](mailto:WFRENTZ@USDEAFSOCCER.COM) (MEN'S EVENT), OR [SANDREWS@USDEAFSOCCER.COM](mailto:SANDREWS@USDEAFSOCCER.COM) (YOUTH EVENT) TO GET APPROPRIATE AUTHORIZED USADSA STAFF CONTACT INFORMATION FOR SUBMISSION.**