RWJBarnabas HEALTH

Matthew J. Morahan III
Health Assessment Center for Athletes
Playing it Safe Participation Form

Patient Information: DATE: _______________

First Name: ______________________ MI___ Last Name:_______________________

Date of Birth: Month:__________ Day: ______ Year: _________________

Gender (Please circle one) Male Female School Name:_____________________

Address: ____

City,State:______________________________________ Zip: _______________

Telephone: ___________________________Second Phone: _______________________________

Parent/Guardian Name:

____

Primary Physician:

____

Physician's Address:

____

Physician's Telephone: ____

Physician's Fax Number: ____

Disclosure of Health Information

In any case where we are notified of a diagnosed concussion regarding this patient, in providing us with the name of the patient's Pediatrician and/or Neurologist you are authorizing us to disclose the patient's health information to that physician to assist us and that physician in the treatment and care of the patient, your child.
I have read and agree to the above statement.

Parent/Guardian Signature _______________________Date:_________________________

Parent/Guardian(Printed Name)________________ Patient(Printed Name)___________________

FOR OFFICE USE ONLY:
Referral Source:
- □ School/Team: ____________
- □ MD: ____________________
- □ ED
- □ Self

Test Type: □ Baseline □ Post Inj 1 2 3 4
□Cash □Check#___□Charge □Contract