AMERICAN ALL-STAR, LLC
MEDICAL HISTORY FORM

This form and the accompanying Medical Authorization Release Form must be completed by each participant identified below ("Participant") and by Participant's parent or guardian (if Participant is under 18 years of age) and returned to American All-Star, LLC before Participant may attend or participate in an American All-Star, LLC sponsored activity. Participant and Participant's undersigned parent or guardian may be hereinafter referred to collectively as "Applicants". This form and the accompanying Medical Authorization Release Form may be released to any third party in order that Participant may receive medical care in the event of illness or injury. This form must be completed in full and signed by all parties referenced herein. Please print or type.

NAME____________________DATE OF BIRTH____________
ADDRESS____________________SSN____________
CITY____________STATE____________ZIP____________
PARENT/GUARADIAN/SPOUSE NAME____________________
PARENT/GUARDIAN/SPOUSE HOME PHONE (   )____________WORK PHONE (   )____________
FAMILY PHYSICIAN NAME____________OFFICE PHONE (   )____________
ADDRESS____________EMERGENCY PHONE (   )____________
CITY, STATE, ZIP____________HOSPITAL____________

1. Date of last Tetanus Immunization or booster shot received by Participant ____________
2. Name(s) of any medical condition(s) for which Participant is currently being treated ____________
3. List all medications Participant is currently taking____________
4. List all vitamins and supplements that Participant is currently taking____________
5. List all medications Participant is allergic to____________
6. List all of Participant's known allergies____________
7. List any restrictions of physical activity that apply to Participant____________
8. Detail any other medical information you feel is important for the safety of Participant____________

In consideration of American All-Star, LLC, allowing Participant to participant in an American All-Star, LLC sponsored activity, Applicants consent to and/or agree to the following:

Applicants represent, warrant, and verify that Participant is free from illnesses and injuries and that Participant is physically fit and sufficiently trained to participate in all activities associated with the American All-Star, LLC sponsored activity. Participant's participation in activities and events sponsored by American All-Star, LLC is voluntary. Applicants consent to administration of first aid and/or other medical treatment to Participant in the event of injury or illness and release and indemnify American All-Star, LLC from any and all liability or claims arising out of said administration of first aid and/or other medical treatment.

The undersigned parent or guardian of Participant hereby represents and warrants that he/she is the legal guardian of Participant and that he/she is authorized to bind himself/herself and Participant to the terms and conditions set forth herein. The undersigned parent or guardian agrees to indemnify, defend, and hold harmless American All-Star, LLC and/or their respective members, managers, representatives, officers, directors, employees, agents, successors, assigns, medical personnel, and invitees ("Releasees") from any loss, liability, cost, claim, or damages whatsoever that may be imposed upon Releasees because of any defect or lack of authority to take the actions described herein on behalf of the Participant. The undersigned parent or guardian has read and understands all of the above and voluntarily signs this document. The undersigned parent or guardian further agrees that he/she has not relied upon any representations, statements, or inducements apart from the foregoing written agreement.

Signature of Participant: ____________________Date:____________

Signature of Parent/Guardian:____________________Date:____________

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MEDICAL AUTHORIZATION RELEASE FORM

NAME OF PATIENT: ____
ADDRESS: ____
____

SOCIAL SECURITY NO.:_______________________________ DOB: ___________________________

PERSON/PERSONS/FACILITY RELEASING INFORMATION:
NAME: ____
ADDRESS: ____
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INFORMATION TO BE RELEASED:
DATES OF TREATMENT: ANY AND ALL TREATMENT AT ANY TIME WHATSOEVER.
TYPE OF INFORMATION TO BE RELEASED: A **complete** copy of: 1) All records, including medical records, dental records, therapy records, hospital records, reports, charts, graphs, accident reports, emergency room records, admit sheets, histories, consults, x-ray reports, radiographic reports, electrocardiograms, electroencephalograms, laboratory reports, nurses' notes, physicians' notes and orders, temperature charts, operative reports, discharge summaries, outpatient records, correspondence; 2) All computer generated health summary records; 3) All radiograms, x-ray films, CT scans, MRIs, myelograms, discograms, and other radiographic studies; 4) All computer data, disks, files, summaries, and information; and 5) All other medical information concerning medical care, attention and confinement of and to the patient named above.

WHO AND WHERE TO SEND INFORMATION:
NAME: Allison Nihart
ADDRESS: American All Star, LLC
1774 Orleans Ave.
Mandeville, Louisiana 70448
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PURPOSE OF RELEASE: Medical care and treatment of the above-named patient.

The following information will be released when included in the above requested information unless you indicate otherwise:

[X] HIV, AIDS, and/or sexually transmitted disease test results
[X] Hepatitis B & C, and/or Sickle Cell Anemia test results
[ ] Other Specified: ___________________________________
[X] Psychiatric and/or mental care and treatment
[X] Alcohol, drug, and/or substance abuse treatment

I understand that:

1. I may refuse to sign this authorization, and it is strictly voluntary.
2. My treatment, payment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization. I can inspect or copy the protected health information to be used or disclosed.
3. I may revoke this authorization at any time by notifying the above named health care provider in writing, but if I do not, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health plan provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable fee, if I ask for it.
6. I may make a copy of this form after I sign it.
7. A photocopy of this document shall be deemed as authentic as the original, and may be used to secure the above-described medical records by facsimile transmission, U.S. mail, national overnight currier, and/or hand delivery.
8. This release further authorizes verbal communications by the health care provider(s) to the requesting party.

This authorization will expire one (1) year from the latest date of execution below.

Signature of Patient:____Date:______________________

Signature of Patient Representative:________________________________Date:______________________

Print Name of Representative:____________________________________Relationship to Patient:________

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