Functional Movement Screen/Y Balance Test Informed Consent

Evaluation and Treatment Objectives:
I understand the fundamental movement patterns that I will be asked to perform are for the purpose of determining asymmetries, motor control and stability/balance deficits which result in functional movement deficiencies. The Functional Movement Screen (FMS) and/or Y Balance Assessment aim(s) to identify imbalances in mobility and stability during movement patterns. The individual and composite movement scores will be used by Velocity Sport's staff members and Bailey Sports Performance and Physical Therapy to determine appropriate corrective exercises and/or stretches to enhance the athlete's performance.

Explanation of the Functional Movement Screen and Y Balance Assessment:
The FMS is a tool used to identify asymmetries which result in functional movement deficiencies. The FMS aims to identify imbalances in mobility and stability during seven fundamental movement patterns. These movement patterns are designed to provide observable performance of basic locomotor, manipulative and stabilizing movements by placing an individual in extreme positions where weaknesses and imbalances become noticeable if appropriate mobility and motor control is not utilized.

The Y Balance Test is used to assess dynamic balance. This test requires the individual to stabilize his/her body with one leg or arm while simultaneously reaching with the other leg or arm into 3 directions. A composite test score is calculated with reference to leg length.

Description of Potential Risk/Discomfort
You may experience an increase in muscle soreness with the evaluation/treatment. There are everyday risks experienced while working and performing activities of daily living. As such, this evaluation/treatment presents no greater risk than those associated with working and activities of daily living. There are expected, normal responses that may occur during the evaluation/treatment**.** These include, but are not limited to, increased heart rate, blood pressure, and respirations associated with physical exertion. As with all activities, a remote possibility exists of re-injury or of developing a new injury. The possibility also exists of abnormal systemic responses during the evaluation/treatment including, but not limited to, fainting, unsafe heart rate, blood pressure etc. In extremely rare instances heart attack, stroke, or death may occur. **Every effort will be made to minimize these risks by the provision of appropriate supervision during the evaluation/treatment.**

Responsibility of the Participant
I understand information I may possess about my health status or previous experiences of unusual feelings with my physical effort may affect the safety and value of my test results. I also understand that in order for the evaluator to make the appropriate recommendations, I should participate to my maximal level. I understand that I should promptly report unusual feelings, discomfort and/or pain during the FMS or Y Balance Test

Inquiries
Any questions about the procedures used during the FMS and/or Y Balance Test are encouraged. I understand that if I have any doubts or questions, I will ask for further explanation from the evaluator and that I will be given an explanation.

Freedom of Consent
I understand my permission to perform the FMS and/or Y Balance Test is voluntary. I am free to deny consent or stop the FMS and/or Y Balance Test at any time if so desired.

I have read the foregoing information and understand it. Questions concerning the FMS and/or Y Balance Test must be answered to my satisfaction. I also understand that I am free to withdraw consent and discontinue participation at any time. I also verify I have provided accurate information regarding my condition, health history, physical examination and fitness.

Patient Release of Information
I hereby give permission to my physicians and case managers to release my medical information to Bailey Sports Performance and Physical Therapy. I also hereby authorize Bailey Sports Performance and Physical Therapy to furnish all information it may obtain during the Functional Movement Screen and/or Y Balance Test to myself, my insurance company or its insurance representatives, my physician and coaches. This authorization shall remain valid for a period of one year or until evoked by me in writing.

_____ _____
Signature Printed Name

_____ _____
Parent or Guardian Signature (If under the age of 18 yo) Address

_____
Date