CONSENT FOR MEDICAL TREATMENT

I am the **PLEASE CIRCLE ONE** Mother Father Legal Guardian of____,

who participates in co-curricular activities for Alcester-Hudson High School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the Alcester-Hudson School District while on a school-sponsored activity and hereby appoint said employee to act on behalf in securing necessary medical services from any duly licensed medical provider.

Dated this_________________________day of________________________________, 20________

Parent(s)/Legal Guardian Signature:____

CONSENT OF CHILD

I, ____, have read the above Consent For Medical Treatment

Form signed by my **(PLEASE CIRCLE ONE)** Mother Father Legal Guardian and join with **(PLEASE CIRCLE ONE)** him her in the consent.

Dated this______________________day of____, 20________

Student's Signature:____

Insurance Company:____ **Policy#**______________________________
Family Doctor: ____
Hospital Preference: ____

Father Day/Work #____________________ **Cell#**____________________
Mother Day/Work#____________________ **Cell#**____________________

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Students Name__________________ Date of Birth__________ Grade_____ Gender F ☐ M ☐

1. I authorize the use or disclosure of the above named individual's health information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in South Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, medical providers and other school personnel involved in the care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in extracurricular activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on July 1, 2018.
6. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in extracurricular activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

____________________________________ ______________________
Signature of Parent Date