ATHLETIC DEPARTMENT EMERGENT AND NONEMERGNT MEDICAL AUTHORIZATION

School Name: _____

Student's Name _____
(First) (Middle) (Last)

Birth Date _____ Grade _____ Sex _____ Home Phone _____

Address _____ Zip _____

Mother _____ Birth Date _____

Occupation _____ Workplace _____ Business Phone _____

Father _____ Birth Date _____

Occupation _____ Workplace _____ Business Phone _____

Insurance Carrier _____ Plan _____ Policy # _____ Phone _____

In the event parents guardians cannot be contacted, please contact: _____

_____ Phone _____

Sports Athlete plays _____

I hereby give consent for any emergency or non-emergency care or treatment deemed necessary by the health care providers (e.g. physicians, physician assistants, and or athletic trainers) designated by school authorities and sponsors and or for transportation to a hospital emergency room for treatment for any illness or injury resulting from or occurring in conjunction with his her participation in this activity. To the extent permitted by law, I waive any claim against such health care providers, school authorities, and sponsors arising out of any care or treatment provided to him her in good faith for any illness or injury arising from or occurring in conjunction with his her participation in this activity.

The undersigned parent(s) or guardian(s) hereby authorize all medical providers (including, but not limited to, athletic training staff, physician assistants and physicians) providing treatment pursuant to this consent to disclose any and all protected health information concerning any and all treatment received by the above-mentioned student pursuant to this consent, as reasonably necessary to and for the purpose of informing school officials (including, but not limited to, coaches and school athletics staff) about the student's prognosis and status. This authorization will expire at the conclusion of the school year to which this consent applies.

The undersigned parent(s) or guardian(s) understand that treatment is not conditioned upon the execution of this authorization. The undersigned parent(s) or guardian(s) understand that if protected health information is disclosed to school officials, that information may be re-disclosed and no longer protected by HIPAA regulations under 45 C.F.R. 164.500 *et seq*. The undersigned parent(s) or guardian(s) understand they may revoke this authorization at any time by providing a written notice to the designated privacy officer of Salina Regional Health Center, Inc.

_____ _____
Signed (Parent or Guardian) Date