CONSENT FOR MEDICAL TREATMENT

I am the mother / father / legal guardian of (student named below) who participates in activities in the Sioux Falls Public School System. I hereby consent to any medical services & hospital care that may be required while said student **is under the supervision** of an employee of Sioux Falls Schools while involved in a school-sponsored/approved activity. I hereby **appoint said** employee to act on my behalf in securing necessary medical services & hospital care from any duly licensed health care provider.

HEALTH HISTORY

Student's Name: _____ ID #: _____

Address: _____

Phone Number: _____

Student's Religion (optional): _____

Parent/Legal Guardian: _____

Address: _____ Phone: _____

Insurance Company: _____ Insured Person: _____

Policy Number: _____

Father/Step-Father Work Phone: _____

Mother/Step-Mother Work Phone: _____

If we are unable to reach you in an emergency, whom should we contact?

Emergency Name: _____

Relationship: _____ Phone: _____

Emergency Name: _____

Relationship: _____ Phone: _____

Hospital Preference: _____

MEDICAL INFORMATION

Family Doctor: _____ Date of Last Tetanus Shot: _____

Any Allergies: _____

Any Major Medical Problems (i.e. Heart, blood pressure, diabetes):

_____

Allergic to any Medications: _____

Legal Representative's Signature: _____

Circle one: Parent Legal Guardian Other: _____

CONSENT OF STUDENT

I have read the above consent form signed by my mother / father / legal guardian, & join with him/her in consent.

_____

Student Signature

Authorization for Release of Medical Information (HIPAA)

(Health Insurance Portability and Accountability Act)

Student Name _____

Date of Birth _____

Grade _____ (Fall, 2018) **Gender** F ☐ M ☐

1. I authorize the use or disclosure of the above named individual's health information which may include the Pre-Participation History and Physical Evaluation information pertaining to a student's ability to participate in school-sponsored/approved activities. Such disclosure may be made by a 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 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 by sending a written notice of revocation to the building Principal. I understand that the revocation will not apply to information that has already been released in reliance upon this authorization.
5. This authorization will expire on: **6/30/2019**.
6. I understand that once the above information is disclosed, the recipient may re-disclose it and federal privacy laws or regulations may not protect it and the information.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in activities depends on such authorization. I need not sign this form to ensure healthcare treatment.
8. Notice: Organizations or persons who receive education records as defined by the Federal Educational Rights and Privacy Act (FERPA) may not provide access to such records to any other party without the written consent of the parent/guardian of the student

Legal Representative's Signature: _____ _____

Date

Circle one: Parent Legal Guardian Other: _____

_____ _____

Student Signature **Date**

(Note: Student signature is necessary if student will be 18 or older at any point during school year)