Authorization To Consent To Treatment Of A Minor

PLAYER NAME: _____
(Print) Last / First / Middle

HOME ADDRESS: _____ ZIP: _____

BIRTHDATE: _____ Home Phone: _____
mo/dd/yr

Father's name: _____ Father's Cell: _____

Mother's name: _____Mother's Cell: _____

List another person to be notified in case of emergency if parents are not available:

Name:_____ Cell:_____

Relationship_____

Special Medical Conditions to be noted (i.e. Allergies, Medications, Disorders):_____

_____

_____

(I)(We), the undersigned, parent(s) do hereby authorize Tim Davis or anyone else associated with the Memorial Girls Lacrosse Club (also known as Spring Branch Memorial Lacrosse Club) to act as designee for the above named minor to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is prescribed by, and is to be rendered under the special supervision of, any licensed physician/or surgeon, whether such diagnosis or treatment is rendered at the office of said physician/or surgeon or at a hospital or elsewhere.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being rendered and is given to provide authority and power on the part of our aforesaid designee to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician/surgeon may, for reasons he/she deems appropriate, prescribe.

(I)(We), hereby authorize any hospital, which, has provided treatment to the above named minor to surrender physical custody of such minor to (my)(our) named designee(s) upon completion of treatment. This authorization is given for designee(s) for those times that (I)(We) cannot be reached by telephone at home or work at the numbers listed below.

This authorization is not to be construed as releasing any physician or surgeon from any requirement that he or she adhere to the lawful standard of care in attending to the named minor and is not to be construed as creating any financial responsibility on the part of the Spring Branch Independent School District or the named officials thereof for any health care provided the named minor. **PARENTS ARE RESPONSIBLE FOR PAYMENT.**

This authorization shall become effective as of November 1, 2017 and remain effective until May 31, 2018.

Insurance Information

Insurance information is required. Please provide a photocopy of your insurance I.D. Card and attach to this form.

Insurance Company Name: _____

Policy Number:_____

Group Number:_____

Name on Policy:_____

The Memorial Girls Lacrosse Club
Authorization for the Release of Medical Information (FERPA)

The Family Education Right to Privacy Act (FERPA) is a federal law that governs the release of a student's educational records, including personal identifiable information (name, address, social security number, etc.) from those records. Medical information is considered a part of a student athlete's educational record.

This authorization permits physicians to disclose information concerning my medical status, medical condition, injuries, prognosis, diagnosis, and related personal identifiable health information to the authorized parties as follows: the licensed athletic trainers, team physicians, board members, parent volunteers and athletic staff (including coaches) of the Memorial Girls Lacrosse Club. This information includes injuries or illnesses relevant to past, present, or future participation in athletics.

The purpose of a disclosure is to inform authorized parties of the nature, diagnosis, prognosis or treatment concerning my medical condition and any injuries or illnesses. I understand once the information is disclosed it is subject to re-disclosure and is no longer protected.

I understand that the Memorial Girls Lacrosse Club will not receive compensation for its disclosure of the information. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I may inspect or copy any information disclosed under this authorization.

I understand that I may revoke this authorization at any time by providing written notification to the Board President or head coach of the Memorial Girls Lacrosse Club. Should I choose to revoke this authorization, I understand that I must present the Memorial Girls Lacrosse Club representative with documentation provided by the doctor mandating her directions regarding care or discharge. I understand revocation will not have any affect on actions the Memorial Girls Lacrosse Club had taken in reliance on this authorization prior to receiving the revocation. This authorization expires at the conclusion of the 2017-2018 lacrosse season.

_____ _____

(Signature) Parent or legal guardian **(Signature) Player**

_____ _____

(Print) Name of Parent or legal guardian **(Print) Name of Player**