Medical Consent Form/Authorization to Release Health Information

Student/Athlete Name_____ Date of Birth_____ Grade_____
Social Security Number_____ School_____ Sports_____
Address_____
Provider authorized to release/receive the health information (Athletic Trainer/Physician): **Phillip Shaw, Athletic Trainer**
Entity to receive/release the Health Information (Coach's Name):_____
Address_____
Attention:_____

MEDICAL CONSENT

Consent is hereby granted to the attending physician to proceed with any medical or minor surgical treatment, x-ray examinations and immunizations for the above named student/athlete. In the event of serious illness, the need for major surgery or significant accidental injury (the "Injury"), I understand that an attempt will be made by the attending physician to contact me in the most expeditious way possible. If said attending physician is not able to communicate with me, the treatment necessary for the best interest of the above named student may be given. In the event a major emergency surgery is indicated, the procedure will not be performed unless another licensed physician concurs.

Consent is also hereby granted to the athletic trainer to provide the needed emergency treatment and first aid to the athlete prior to his referral to the attending physician or admission to the medical facilities.

It is specifically understood and agreed by the undersigned that Ouachita Parish High School/Ouachita Parish School Board is not responsible for any such medical expenses incurred by the student/athlete, whether as a result of an injury referral, regardless of the provider, or during any Ouachita Parish High School athletic event.

AUTHORIZATION TO RELEASE HEALTH INFORMATION

The undersigned patient (parent or Legal Guardian) hereby authorizes the Provider named above to release the Health Information to the Recipient named above. The patient (parent or legal guardian) has the right to refuse to sign this authorization. This authorization to release the health information listed above can be revoked at any time (upon written notification) except to the extent that (1) Provider has already released the health information before being notified of the revocation, or (2) Provider has taken action in reliance on this authorization. Provider's Notice of Privacy Practices contains more information on how to revoke this authorization. This authorization will expire one year from date of signature. When the Patient's health information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the Recipient or any of its agents and /or employees. Appropriate patient information related solely to the Injury and its corresponding prognosis may be communicated by the physician or physicians staff to the athletic trainers and school coaches for the purpose of determining the athlete's ability to play sports, or any reduced level of sports related activity.

_____ _____
Signature of Student/Athlete Date

_____ _____
Signature of Parent/ Legal Guardian Date

Phone Numbers where parents / Legal Guardian can be contacted:

Home_____
Office_____

Family Physician Information:_____

Name of Primary Insurance Company_____
Policy #_____
Address of Insurance Company_____
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