CONSENT FOR MEDICAL TREATMENT

I am the _____ (Mother-Father-Legal Guardian) of, _____
who is a student at Gettysburg School District and/or participates in:

a. Potter County extra-curricular activities
b. Co-curricular activities for Gettysburg Public School
c. School sponsored field trips

I understand that in the event of a medical emergency involving my child, I will be notified immediately if possible. However, in the event that I cannot be reached at the time of the emergency, or if the emergency occurs while my child is out-of-town on a school-sponsored trip, I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the Gettysburg School District. I hereby appoint employees of the Gettysburg School District to act on my behalf in securing necessary medical services from any licensed physician or osteopath. It is understood that the Gettysburg School District and its employees are not responsible for any financial cost incurred as a result of securing medical service.

Dated this _____ day of _____ , _____ .

Parent's Signature: _____

Known Allergies: _____

Current Medications: _____

Emergency or Cell Phone Number(s): _____
_____
_____
_____

CONSENT OF STUDENT

I, _____
_____ , have read the above Consent form signed by my _____
_____ (Mother-Father-Legal Guardian) and join with _____ (him/her) in the consent.

Dated this _____ day of _____ , _____ .

Student's Signature: _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Students Name _____ Date of Birth _____

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

This form must be completed annually and must be available for inspection at the school