CONSENT FOR MEDICAL TREATMENT FORM

Student Name ______________________ **Grade** _______ **Date of Birth** _______________

I,_____________________________________, am the (circle one) Parent or Legal Guardian of, _____________________________________, who is a student at the 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 necessary medical services that may be required while said child is under the supervision of an employee of the afore-mentioned school/coop. I hereby appoint said employees to act on behalf of myself in securing necessary medical services from any duly licensed medical provider. Signatures on this form do not constitute consent for vaccinations of any kind. It is understood that the Gettysburg & Hoven School Districts and its employees are not responsible for any financial cost incurred as a result of securing medical service.

_____________________________________ _______________________

Signature of Parent/Legal Guardian **Date**

Known Allergies: ____

Current Medications: ____

Emergency or Cell Phone Number(s): ___________________________

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____

CONSENT OF PARTICIPANT (for all students to complete)

I, ______________________________, have read the above consent for medical treatment form signed above, or, as an individual of majority age, consent to those same medical services and actions as indicated above on this form.

_____________________________________ _______________________

Signature of Student **Date**

SDHSAA CONSENT FOR MEDICAL RELEASE FORM (HIPAA)

Student Name: ____________________________ **Grade:** _____________ **Date of Birth:** _________________________

I/We the undersigned do hereby:

1. 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 for the purposes of evaluating, observing, diagnosing and creating treatment plans for injuries that occur during the time period covered by this form, or, from pre-existing conditions that require care plans pertaining to participation during the time period covered by this form.

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 medical care of this student.

3. This information for which I/we are 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, 2023.

6. I understand that once the above information is disclosed, there is potential for it to be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Schools, School districts and school personnel are to uphold the bounds of FERPA. As such, disclosure and re-disclosure by schools or school employees must be done in compliance with FERPA guidelines.

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**

____ ____________________________

Signature of Student (if over 18 or turning 18 before July 1, 2023) **Date**

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