STUDENT ATHLETE AUTHORIZATION & CONSENT FORM

I, _____, the parent guardian of _____, a student-athlete participating in interscholastic athletic sports, understand that the disclosure of the student athlete's protected health information is a condition of participation at Belleville Township District 201 (BTHS).

I, hereby authorize/consent for physicians covering BTHS 201 athletic events and Memorial Hospital's Certified Athletic Trainer and other health-care personnel participating with the BTHS's athletic program to release information regarding my student athlete's protected health information (PHI) and related information regarding and injury or illness which may occur during the student-athlete's training for and participation in athletics at BTHS to any coach, athletic director, or school official in connection with my student's participation in interscholastic sports. This protected health information may concern the student athlete's medical status, medical condition, injuries, prognosis, diagnosis, athlete participation status and related personally identifiable health information. This protected information may be released to other health-care providers, hospital and/or medical clinics and laboratories, athletic coaches, athletic trainers, medical insurance coordinators, athletic and or school administrators, and officials of the student athlete's sport.

I understand that my student athlete's protected health information may be protected by federal regulations under the Health Information Portability and Accountability Act (HIPAA) and, if so, may not be disclosed without parent/legal guardian's authorization.

I understand as a parent or guardian of the student athlete:

- This authorization / consent is valid for the duration of the school year of the student-athlete, unless I rescind my permission in writing to Belleville Township High School.
- A revocation will not affect any uses or disclosures that the school, Southern Illinois Sports Medicine, and Memorial Hospital's Certified Athletic Trainers made before it received my student's revocation.
- If I request it, I may see a copy of the PHI described in this form.
- The information that is used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA. I have the right to seek assurances from the above named entities or individuals authorized to receive the information that they will not re-disclose information to any other party without my further authorization.

CONSENT FOR TREATMENT

I , the parent /Guardian of the above name student understands that my student-athlete may be injured while participating in school sponsored athletics. I hereby grant permission to physicians covering BTHS 201 athletic events and Memorial Hospital's Certified Athletic Trainer to administer any preventative, first aid or emergency treatments to evaluate and examine, which they deem reasonably necessary to the health and well-being of my student-athlete.

I further understand and consent to the Certified Athletic Trainer's providing advice to my student athlete concerning nutrition, hydration, and conditioning. The Certified Athletic Trainer may also provide to my student athlete hot or cold packs, wound care, taping, massage, whirlpool treatment and therapeutic exercises which I also authorize and consent to be performed on my student-athlete during his/her participation in school sponsored athletics

_____	_____	_____
Print Student-Athlete's Name	Student-Athlete Signature	Date
_____	_____	
Sport played/plan to play	Year in School (Fr., Soph., Jr., Sr.)	
_____	_____	_____
Print Parent/Guardian Name	Parent/Guardian Signature	Date