2019-2020 Authorization to Consent to Treatment of a Minor CFI

Student's Name_____ Birthdate:_____/_____/_____ Student ID#:_____
Print (Last),(First)(Middle (Mo) (Day) (Yr)

Sex: (circle one) M F Grade Level:_____ Sport_____

Home address:_____ Zip:_____

Home phone w/area code:_____

Father's name:_____ Business/Cell phone:_____

Mother's name_____ Business/Cell phone:_____

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

1._____ Relationship:_____

Home phone:_____ Business/Cell phone:_____

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

_____

(I)(We), the undersigned, parent(s) do hereby authorize any official of Spring Branch Independent School District 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_____ 20_____ and remain effective until_____ 20_____

Authorization for the Release of Medical Information

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, and athletic staff (including coaches) of Spring Branch ISD. 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 Spring Branch ISD 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 head athletic trainer at the respective high school. Should I choose to revoke this authorization, I understand that I must present the SBISD licensed athletic trainer with documentation provided by the doctor mandating his/her directions regarding care or discharge. I understand revocation will not have any effect on actions Spring Branch ISD had taken in reliance on this authorization prior to receiving the revocation. This authorization expires at the conclusion of each school year.

Student ID#_____

Printed Name of Student:_____

Student Signature:_____

Printed Name of Parent:_____

Parent Signature:_____ Date:_____