Novant Health – Sports Medicine
Student-Athlete Consents and Authorization Form

PARTICIPANT: **PLEASE READ CAREFULLY BEFORE SIGNING. THIS DOCUMENT HAS LEGAL CONSEQUENCES AND WILL AFFECT YOUR LEGAL RIGHTS AND ABILITY TO BRING FUTURE LEGAL ACTIONS.**

PERMISSION TO TREAT

I hereby give my consent and grant permission for medical treatment deemed necessary for any condition arising while participating in interscholastic sports, provided by Novant Health Sports Medicine athletic trainers ("ATCs"). This would include administration of medication(s) such as Albuterol or an Epipen to treat allergic reactions (e.g., anaphylactic reaction) or restrictive airway reactions (e.g., exercise-induced asthma) should such emergent need arise. If my injury/illness requires care not available on site, I understand every effort will be made to contact emergency contact prior to treatment being rendered at an off-site facility. I acknowledge that the ATCs are employees of Novant Health and information regarding my care is shared through the Novant Health network of providers. I also acknowledge that the ATC will release pertinent information to related health care providers and those providers will release pertinent information to the ATC regarding care of my condition.

_____ _____
Signature of the Student-Athlete Date

_____ _____
Printed Date

_____ _____
Signature of the Parent/Legal Guardian (If student-athlete is under 18 years of age) Date

_____ _____
Printed Date

HIPAA AUTHORTIZATION

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 and/or The Family Educational Rights and Privacy Act (FERPA) of 1974 require Novant Health to guard the privacy of your protected health information. You have the right to confidential treatment of all information and records pertaining to your care; as well as full consideration of privacy concerning your treatment and rehabilitation plan. You also have the right to be advised as to the reason for the presence of any individual during the course of your medical care. **If you sustain an injury while participating in interscholastic athletics at _____ ("School"), Novant Health may discuss issues relevant to your care only under the following circumstances:**

1. **You have given oral or implied consent through your actions.**
2. **You have signed the authorization form below, which permits us to disclose health information to the parties mentioned.**

This authorizes the certified athletic trainers, physicians, sports medicine staff and other medical personnel representing Novant Health to release information concerning my medical status, medical condition, injuries, prognosis, diagnosis and related personally identifiable health information to the coaches, assistant coaches, other athletics staff, my parents/guardians, and team personnel when deemed appropriate solely by Novant Health. This information includes injuries or illnesses related to past, present or future participation in athletics at School. I

understand that once my health information is released, the recipients of my personal health information may disclose or share my information with others and my information may no longer be protected by federal and state privacy protections. I have a right to receive a copy of this form upon request.

I understand that I may inspect or copy any information used under this authorization. I understand that I may cancel this authorization at any time by providing written notice to the Novant Health- provided Head Athletic Trainer in writing. Any cancellation will apply only to information not yet released by Novant Health. I understand that refusing to sign this form will not prevent my ability to get treatment. This authorization is valid for the duration of the student-athletes' interscholastic athletic career at School. Therefore, it expires when the student-athlete no longer participates in athletics offered by School.

_____ _____

Signature of the Student-Athlete Date

_____ _____

Signature of Parent/Legal Guardian (If student-athlete is under 18 years of age) Date

Legal Name of Participant _____Date of Birth _____

Address _____

Phone _____ Email _____

Have you ever been a patient at a Novant Facility or NH Physician? Yes____ No _____

Name of Primary Care Physician: _____

Medical Allergies: _____

Current Medications: _____

Past Serious Medical Conditions: _____

_____

Emergency Contact Information

Name: _____ Relationship: _____

Phone: _____ Alt Phone: _____