

CAMPBELL COUNTY SCHOOL DISTRICT
ASSUMPTION OF RISK/MEDICAL/HIPAA CONSENT

Student Name _____ Activity _____ Age _____ Grade _____

I/We hereby acknowledge that we have been properly advised, cautioned and warned by the proper administrative and coaching personnel of Campbell County School District, that by participating in a sport, I am exposing myself to the risk of serious injury, including but not limited to, the risk of sprains, fractures and ligament and/or cartilage damage which could result in a temporary or permanent, partial or complete, impairment in the use of my limbs; brain damage; paralysis, or even death. Having been so cautioned and warned, it is still my desire to participate in the sport, and should I choose to participate in the sport, I hereby further acknowledge that I do so with full knowledge and understanding of the risk of serious injury to which I am exposing myself by participating.

I/We give authorization to the athletic trainer or physician to evaluate and treat any injuries that occur while participating in activities at Campbell County School District. (This includes immediate first aid and treatment, X-ray, physical exam, follow-care, and rehabilitation.)

As with any injuries, there could be financial obligations. Campbell County School District requires, as protection for the student as well as the parents/guardians, that each participant be insured during their activity season(s). This responsibility is solely up to the parents/guardians, and failure to maintain insurance coverage does not remove the financial responsibility from the parent. Nor does it encumber Campbell County School District for medical costs related to activity injuries.

The Health Insurance Portability and Accountability Act (HIPAA) contains regulations that establish standards to protect security of health information, specifically oral and written health information collected or maintained by health providers. I/We hereby authorize the athletic trainers to release information regarding any injury or illness during the student-athlete=s training for and participation in athletics in Campbell County School District. This authorization/consent will allow athletic trainers to disclose medical information to coaches, school officials, and athletic directors on a need to know@ basis. This will ensure the safety of the athlete while participating in school sports, as well as establish a communication channel for school officials to stay abreast of an athlete=s playing status and condition.

PARTICIPANT=S SIGNATURE _____ DATE _____

PARENT/GUARDIAN=S SIGNATURE _____ DATE _____

FATHER=S NAME _____ PHONE (Hm) _____ (Wk) _____

MOTHER=S NAME _____ PHONE (Hm) _____ (Wk) _____

ADDRESS _____ TELEPHONE _____

_____ SCHOOL ATTENDING _____

IF PARENT CANNOT BE REACHED, WHO SHOULD CLAIM RESPONSIBILITY OF THE ATHLETE?

NAME _____ RELATIONSHIP _____ TELEPHONE _____

FAMILY PHYSICIAN _____ TELEPHONE _____

INSURANCE CO. _____ POLICY # _____

(REQUIRED)

(REQUIRED)

PLEASE LIST ANY MEDICATIONS, KNOWN ALLERGIES TO MEDICATIONS, OR OTHER MEDICAL CONDITIONS.

White: Head Coach Yellow: Trainer Pink: Assistant Coach Coach
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