

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM (HIP AA)

Students Name _____ Date of Birth _____

1. I authorize the use or disclosure of the above named individual's health and injury information including the Initial and Interim Pre-Participation History and Physical Exam information pertaining to a student's ability to participate in North Dakota High School Activities Association sponsored activities. Such disclosure may be made by any Health Care Provider generating or maintaining such information.
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 care of this student.
3. This information for which I am 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 relating to health conditions or injuries during the year that may effect participation.
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.
5. I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
6. 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.
7. This authorization will expire one year from the date of signature.

Signature of Student

Date

Signature of Parent

Date

SCHOOL _____

STUDENT'S NAME _____

STUDENT ACKNOWLEDGEMENT OF RISK AND WARNING

I, _____ hereby acknowledge that I have been properly advised, cautioned,
(Name of Student)
and warned by the proper administrative and coaching personnel of _____
that by participating in the activities of _____, I am exposing myself to risk of serious
(Name of Activities)
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 above activities, and should I choose to participate in the above activities, 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 in the above activities. **I have also received and read the Sanford Health
concussion document and understand the risks of participation in the above activities.**

DATE _____ STUDENT'S SIGNATURE _____

PARENTAL ACKNOWLEDGEMENT OF RISK AND WARNING

We/I, the parent(s) of _____ do hereby acknowledge that we/I have
(Name of Student)
been fully advised, cautioned, and warned by the proper administrative and coaching personnel of
_____ that our/my child named above may suffer serious injury including, but not
limited to, sprains, fractures, brain damage, paralysis, or even death by participating in the activities of
_____. (Name of Activities)
Notwithstanding such warnings, and full knowledge understanding of the risk of serious injury to our/my
child named above which may result, we/I give our consent to _____ participating in the
(Name of Student)
_____.
(Name of Activities)

**I have also received and read the Sanford Health concussion document and understand the risks o
participation in the above activities.**

DATE _____ SIGNATURE OF PARENT/GUARDIAN _____