



STUDENT'S NAME _____

STUDENT ACKNOWLEDGEMENT OR 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 Oak Grove Lutheran School that by participating in the activities of _____, I am exposing

(NAME OF ACTIVITIES)

myself to 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 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 participate 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 OR RISK AND WARNING

We/I, _____ hereby acknowledge that we/I have been properly advised,
(NAME OF STUDENT)

cautioned, and warned by the proper administrative and coaching personnel of Oak Grove Lutheran School 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

_____, Notwithstanding such warnings and full

(NAME OF ACTIVITIES)

knowledge understanding of the risk of serious injury to our/my child named above which may result, we/I give our consent to _____ to participate in

(NAME OF STUDENT)

_____.

(NAME OF ACTIVITIES)

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

DATE _____ PARENT'S SIGNATURE _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION FORM (HIPAA)

Student's 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 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 affect 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 disclose, it may be re disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.
6. I understand authorizing the use or disclose 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