

**SPENCER HIGH SCHOOL & MIDDLE SCHOOL  
ATHLETIC PERMIT CARD**

20\_\_\_\_ - \_\_\_\_ Level \_\_\_\_\_  
(MS or HS)

STUDENT \_\_\_\_\_ GRADE \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

BIRTH DATE \_\_\_\_\_  
Month/Day/Year

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

If no answer, please phone in case of emergency

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

History of Diabetes or Epilepsy \_\_\_\_ Yes \_\_\_\_ No

Asthma \_\_\_\_ Yes \_\_\_\_ No Do they use an inhaler? \_\_\_\_ Yes \_\_\_\_ No

Allergies to Sulfa, Penicillin, etc. (Please list) \_\_\_\_\_

**MEDICAL RELEASE**

I hereby give my consent for the above named student to be medically treated by the professional staff of Sports Medicine Northwest, as they deem necessary, for the safe participation of the student. Also, I give permission for necessary information to be shared with the coach.

\_\_\_\_\_  
(Parent/Guardian Signature)

\_\_\_\_\_  
(Date)

**INSURANCE RELEASE**

**OUR CHILD IS COVERED:**

\_\_\_\_\_A. I do not wish to purchase the school insurance. We, the undersigned, feel we have adequate insurance protection for our son/daughter while practicing or participating in INTERSCHOLASTIC SPORTS, or other school sponsored activities.

\_\_\_\_\_B. I plan on insuring my student under the Security Life Insurance Plan. Insurance forms are available at the high school and middle school principal offices. Insurance forms are handed out at school registration in August and the head varsity coaches distribute forms to the athletes.

**If purchasing school insurance please make all checks payable to:  
STUDENT ASSURANCE SERVICES, INC.**

**ATHLETIC PARTICIPATION**  
**For the Student and the Parent**

By signing below, I (we) state that I (we) have read and understand the following and my son/daughter has my permission to practice and compete in the interscholastic program.

1. I (we) attended or will attend any informational meeting conducted by the activity director and/or various coaches.
2. I (we) understand that accidents may occur in athletics even though normal acceptable safety precautions have been taken.
3. I (we) have received a copy of the Student Activities Code and have read the policies governing the activities program and understand them fully. I (we) agree to abide by these policies while involved in the activities of the Spencer High School and Spencer Middle School and am aware of the consequences for violating the policies.

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

**This sheet** along with a current **physical examination form** *must be on file* in the activity director's office **before participation** will be allowed. An athlete may be suspended or dropped from a team for the remainder of the season for falsification of physician's signature, parent or guardian's signature on an athletic permit card.

**CONSENT FOR TREATMENT**

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ School: \_\_\_\_\_

I hereby authorize licensed athletic trainers acting on behalf of Spencer Hospital to validate and treat any injury that occurs as a result of the student's participation in athletics at the School. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries both at the School, at practices and Games, and for medical evaluation and treatment at the Saturday Injury Clinic offered by Spencer Hospital by an athletic trainer or contacted physician.

I understand that athletic trainers are limited in their scope of practice under state law and cannot be a substitute for or render the independent medical judgement and medical treatment available from licensed physicians.

I understand that while the School has contracted with Spencer Hospital for athletic trainer services and the availability of the Saturday Injury Clinic in Spencer, I have the right at any time to seek medical care for the Student from any physician or other medical provider. I also understand that I should obtain services beyond the scope of these athletic trainer services and Saturday Injury Clinic from medical providers of my choosing.

**NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand that I should read it carefully.

I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling 712-264-6198, or by accessing our website at [www.spencerhospital.org](http://www.spencerhospital.org), or by requesting one at this office.

**AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION**

I hereby authorize Spencer Hospital (the "Hospital") to disclose to the School's athletic coaches and other appropriate administrators my protected health information created or obtained by the Hospital in the course of providing athletic trainer services and conducting an injury clinic. This disclosure is made at my request.

The Hospital may disclose any and all information which it has created or obtained regarding my care by athletic trainers and at the injury clinic.

I understand and acknowledge that:

1. I can revoke this Authorization at any time by giving my written revocation to the Hospital at the following address: Spencer Hospital, 1200 First Avenue East, Spencer, IA 51301. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
2. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
3. Spencer Hospital may not condition future treatment on my signing this authorization. However, I understand that my refusal to sign this authorization may affect the Student's ability to participate in School athletic programs.
4. This Authorization is effective until revoked.

A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.

\_\_\_\_\_  
Printed Parent/Guardian Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

SPENCER HOSPITAL/SPORTS MEDICINE N.W.  
CONSENT FOR TX – RELEASE OF INFORMATION  
SPENCER, IA 6/10