



Protected Health Information Authorization

For Release of Information

School: _____ **Greenwood High School** _____

I hereby authorize any medical provider associated with my school/organization, specifically PlaySafe to use and/or disclose my clearance and health recommendations to the athletic director, coaches, athletic trainers and medical personnel at my school/organization to inform them of my health status for the participation in athletics or activities. I understand that my refusal to sign this authorization may affect my child's ability to participate in athletics. Medical information to be disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by the state or federal law.

Athlete's Printed Name: _____

Date: _____ **Athlete's Signature if 18 or older:** _____

Parent's Printed Name: _____

Date: _____ **Parent/Guardian Signature:** _____



PlaySafe - Medical & Emergency Information

Name On Birth Certificate (Last, First, MI) _____

Preferred Name _____

DOB _____ Grade _____ Sport(s) _____

Address _____

Mother/Guardian _____ Contact # _____

Work Contact# _____ Email _____

Father/Guardian _____ Contact# _____

Work Contact # _____ Email _____

Insurance Carrier _____

Claim/Policy # _____

Emergency Contact (Non-Parent/Guardian) _____ Phone # _____

Primary Care Physician _____ Phone # _____

Please list any injuries, allergies, or other medical history that you feel may be important in case of an emergency:

Other

Is your child on any medication that is taken on a regular basis? (List)

My child may take any over-the-counter medication such as Tylenol, Advil, etc. or topical ointments such as Neosporin, hydrocortisone, etc. as needed **Yes or No**

I grant permission for my son/daughter to practice and play in athletic events for _____ High School. I will not hold the school responsible in any way whatsoever, except where gross negligence exists. I also grant permission for treatment deemed necessary for a condition arising during participation in the activity, including medical or surgical treatment recommended by a medical doctor. I understand that every effort will be made to contact me prior to treatment.

Athlete's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

