

NAME: _____ SPORT(S): _____

PROTECTED HEALTH INFORMATION AUTHORIZATION FOR RELEASE OF INFORMATION

I/We hereby authorize any medical provider associated with **Gallatin High School** to use and/or disclose my child's clearance and health recommendations to the athletic director, coaches and medical personnel at **Gallatin High School** to inform them of their health status for the participation in athletic or activities. I/We understand 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 state or federal law.

Name of Parent/Guardian: _____ Date: _____

Parent/Guardian Signature: _____

LEGAL MEDICAL CONSENT

I/We hereby give consent for (student-athlete's name) _____ to represent **Gallatin High School** in athletics realizing that such activity involves the potential for injury. I/We acknowledge that even the best coaching, use of the most advanced equipment, and strict observance of rules, injuries are still possible. On rare occasions these injuries are severe and result in total disability, paralysis, or even death. I/We further grant permission to **Gallatin High School** and TSSAA, its physicians, athletic trainers, and/or EMT to render aid, treatment, medical or surgical care deemed reasonably necessary to the health and well being of the student-athlete named above during or resulting from participation in athletics. By the execution of this consent, the student athlete named above and his/her parent/guardian(s) do hereby consent to screening, examination, and testing of the student athlete during the course of the pre-participation examination by those performing the evaluation, and to the taking of medical history information and the recording of that history and the findings and comments pertaining to the student athlete on the forms attached hereto by those practitioners performing the examination. As parent or legal guardian, I/We remain fully responsible for any legal responsibility which may result from any personal actions taken by the above named student-athlete.

Name of Parent/Guardian: _____ Date: _____

Parent/Guardian Signature: _____

INSURANCE COVERAGE

I/We understand that medical bills related to athletic injury are the responsibility of the parent/guardian. Occasionally, student athletes are injured during practices or games and the school needs to ascertain that the parent/guardian has medical insurance in order to cover expenses if an injury occurs.

Please check one of the following and complete the information related to your child's insurance coverage (you may opt to choose more than one). EVERY ATHLETE MUST HAVE INSURANCE TO PARTICIPATE.

_____ I/We have personal insurance on (student-athlete's name) _____.

_____ I/We wish to purchase athletic insurance on (student-athlete's name) _____.

Please choose from coverage shown (Benefit information is available in the front office):

School-Time Only Plan

Economy Plan - \$8.00 _____ Basic Plan - \$16.00 _____ Deluxe Plan - \$24.00 _____

24-Hour Plan *without* Extended Dental Benefits

Economy Plan - \$44.00 _____ Basic Plan - \$88.00 _____ Deluxe Plan - \$132.00 _____

24-Hour Plan *with* Extended Dental Benefits

Economy Plan - \$49.00 _____ Basic Plan - \$98.00 _____ Deluxe Plan - \$147.00 _____

High School Football Plan

Economy Plan - \$40.00 _____ Basic Plan - \$80.00 _____ Deluxe Plan - \$120.00 _____

Name of Parent/Guardian: _____ Date: _____

Parent/Guardian Signature: _____