Consent to Treatment and Waiver of Liability Form

I _____ [Name of Parent or Guardian] am the parent or legal guardian of _____ [Name of Student]. I understand that Southeast Georgia Health System (the "Health System") provides athletic training, first aid and certain other medical services in connection with certain athletic events and programs of Frederica Academy, including pre-participation physical examinations. In case of emergency or accident on the school grounds or during any school activity involving the above-name student, which in the opinion of school authorities or personnel of the Health System present requires immediate medical or surgical attention, I hereby grant permission to such school authorities and Health System personnel to render medical treatment and to obtain the services of qualified medical personnel to treat the condition unless I am present and request otherwise or until I later request otherwise. I also authorize that a pre-participation physical examination be conducted on student.

I hereby release and agree to hold harmless Frederica Academy, the Health System, and their employees and agents, including, but not limited to, the Athletic Trainers and the Team Physicians or Team Physician Assistants, from any and all liability in case of accident, injury, damage or other mishap in connection with all medical services or athletic trainer services they provide to the above-named student.

_____	_____	_____
Parent/Guardian Signature*	Telephone Number	Date

Authorization for Release of Medical Information

I authorize the release of medical information to Frederica Academy by physicians and health care providers rendering services to Frederica Academy athletes. The purpose of the release of medical information is to allow Frederica Academy to determine the advisability of an athlete's participation in Frederica Academy athletics. An example would be the release of a screening physical examination. By agreeing to this release of medical information for my son, daughter or other person for whom I have the legal authority to act, I hereby authorize health care providers (including, but not limited to, the Health System and its physicians and athletic trainers) that are contracted with Federica Academy to release to each other and to Frederica Academy oral and written information relating to the athlete's medical or physical condition, illness or injury that may have a bearing upon past, present, or future participation in athletics of Frederica Academy. The medical information will be used by Frederica Academy for the purposes of determining the advisability of the athlete's participation in Frederica Academy athletics. **This authorization is expressly bound by the following conditions:**

- I understand that my protected health information is protected by federal law under Health Information Portability and Accountability Act (HIPAA) may not be disclosed without my authorization under HIPAA.

- I understand that my signing of this authorization/consent is voluntary and I am not required to sign this authorization/consent in order to be eligible for participation in Frederica Academy athletics.

- I understand that seeking treatment at practice, in training room or evaluation/treatment during games may be in the view of the general public. Frederica Academy and the Health System are in compliance with HIPAA regulations, maintain all medical documents and records in confidentiality, but the nature of treatment in these areas allows for other patients, students, athletes, and staff to be in use of these facilities during my treatment. By signing this document, I understand the possible implications and consent to treatment.

- This authorization will automatically expire upon the athlete's termination of participation in or ineligibility to participate in Frederica Academy athletics, except to the extent relied upon for disclosures made prior to the automatic expiration. I have the right to revoke this authorization in writing at any time by sending written notification to the director of athletics at my institution. I understand that a revocation takes effect on its request date and does not affect any action taken prior to that date.

- I understand that there is a potential for information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

- This authorization shall cover actions by and for Southeast Georgia Health System, Cooperative Healthcare Services, Inc. and all of their respective employees, workforce and business associates and all other physicians and healthcare providers contracted with Frederica Academy and their respective employees, workforce and business associates.

_____	_____	_____
Parent/Guardian Signature*	Telephone Number	Date

* This authorization must be signed by a parent, guardian, or other person acting in loco parentis who has the authority to act on the student's behalf. **By signing this form, you as the parent, guardian or a party acting in loco parentis warrant that you have the legal authority to act on the Athlete's behalf.** The signature may be only the athlete if the athlete is over 18 years of age.