

North Dakota High School Activities Association

Box 817

Valley City, ND 58072

Phone: 845-3953

Fax: 845-4935

www.ndhsaa.com

Transfer of Care Form

If you wish to have your own team/personal medical provider be responsible for your athletes, complete this form and return it to the medical staff at the tournament/contest. Team providers must review proper protocol with the event medical personnel prior to the contest and inform them of their specialty.

Transfer of care can be made only to a North Dakota licensed medical provider

I herewith transfer the care of _____ of _____
(Individual name or entire team) (School name)

To _____ for continuing medical services throughout this tournament/contest.
(Athlete's private/team medical provider)

Date Signed

Coach/AD/Principal

School Medical Provider

Tournament Medical Provider

Note: Parents' signature is required for individuals. I affirm I am the parent of the student athlete identified above and I am indeed transferring medical care.

Parent Signature

date signed