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 _____
(Athlete's private/team medical provider)

License No._____ and expiration date_____, for continuing medical services throughout

The _____ held on _____
(tournament/contest) (dates of event)

_____ _____
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(s) identified above and I am transferring responsibility for the medical care of my student athlete(s) to the North Dakota licensed medical provider identified above.

_____ _____
Date Signed Parent Signature