NCCAA COVID-19 CONTACT FORM

Institution _____ **State** _____

I understand that the Health Insurance Portability and Accountability Act of 1996 (HIPAA) prohibits my medical/health information from being shared. In the interest of the health of my teammates, opponents, and others I may have had contact with, I authorize the NCCAA and member institutions to disclose to relevant parties that I have displayed COVID-19 symptoms, have tested positive for COVID-19, or have been exposed to the virus through close contact with someone believed to have the virus.

In disclosing this information, the NCCAA and member institutions will take reasonable measure to keep my identity confidential to the fullest extent possible. However, I recognize that circumstances may require identifying me as the infected or exposed individual in order to properly warn others so they may take precautionary measures and help prevent furthering the spread of the virus. In addition, there may be circumstances when it is not possible to warn others they may have been exposed to the virus without them learning it was through contact with me.

Failure to sign this form will exclude said student-athlete from participation in intercollegiate athletics at his/her institution.

The above statements are applicable for the sport of _____ for the academic year 20___ to 20 ___.

Signature of Student-Athlete	**Print or Type Student-Athlete's Name**	**Date**

As a representative of an institution affiliated with the NCCAA, I hereby certify that the beginning of this certificate has been read to all student-athletes who are practicing or shall practice in the above-named sport.

Athletics Director or Compliance Officer	Institution/State	Date