Midwest Scholastic Rowing Association
Lightweight Health Certificate

Please retain this information for your records, do not send to MSRA.

Online submission due by **April 1, 2017** for athlete to be eligible for competition.

School: _____

Athlete Name, Last: _____First: _____

Gender: M F DOB (mm/dd/yyyy): _____/_____/_____

==========

To be completed by Certified Athletic Trainer/Skin Fold Assessor. MSRA will accept BF% measurements to be performed by any method the certified trainer deems reliable.

Test Date: _____/_____/_____ Alpha Weight: _____ lbs.

Athlete adequately hydrated for testing: Yes_____ No_____

If Skin Fold measurements are being taken to calculate BF% using the MSRA Calculation Worksheet, you must measure these locations (Three measurements each location):

Triceps: _____ _____ _____

Subscapular: _____ _____ _____

Abdominal: _____ _____ _____

Percentage Body Fat: _____

==========

Check Appropriate

___**Female Athletes:** Is the athlete safely able to attain and compete at a weight of **130lbs** AND be at or above **12%** body fat between the above test date and May 13, 2017?

___ Male Athletes: Is the athlete safely able to attain and compete at a weight of **150lbs** AND be at or above **7%** body fat between the above test date and May 13, 2017?

_____

I certify that the above information is accurate.

Signature: _____

Printed Name: _____

Licensing Board/No. : _____

Work Email: _____

_____

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R.
Parts 160 and 164)**

1. Authorization
I authorize _____ (Athletic Trainer) to use
and disclose the protected health information described below to:

Scholastic Rowing Association of America® (SRAA®).

2. Effective Period
This authorization for release of information covers the period of healthcare
from:
___**August 1, 2016_____ to _May 31, 2017**_____.

3. Extent of Authorization

1. I authorize the release of my health assessment and information pertinent to the SRAA® Lightweight Health Certificate.
2. This authorization shall be in force and effect until __May 31, 2017____ at which time this authorization expires.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
4. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

---

Date