AUTHORIZATION FOR SPORTS MEDICINE SERVICES AND CONSENT FOR TREATMENT

I, the undersigned, am the parent/legal guardian of, _____.

(Student athlete name - please print)

I hereby give consent for a Certified Athletic Trainer and/or other sports medicine clinical staff to provide sports medicine services for the above minor.

Sports medicine services include, but are not limited to: administrating first aid for athletic injuries, providing initial treatment and management of acute injuries, and assessing athletic injuries at the request of the athlete, the athlete's coach, organization administration, or the athlete's parent/guardian. The Athletic Trainer and/or sports medicine clinical staff will perform only those procedures that are within their training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. I understand that a written report of any athletic injury assessment for the athlete will be confidentially maintained.

I, hereby authorize the Athletic Trainer and/or other clinical staff who provide services to the above-named athlete to disclose information about the athlete's injury assessments and post-injury status. I understand such disclosures will be done, as needed, with the involved coaching staff, organization administration, any treating healthcare provider and/or consulting concussion management specialist.

Parent/Guardian Name (print)_____Signature_____

Date_____

Relationship to athlete_____

Cell/Work phone_____

Home phone_____