



## AUTHORIZATION FOR SPORTS MEDICINE SERVICES AND CONSENT FOR TREATMENT

I, the undersigned, am the parent/legal guardian of, \_\_\_\_\_, a minor and student  
(Student-athlete name- please print)  
athlete at \_\_\_\_\_ who plans on participating in sports for 2018-2019  
school year. (Name of school)

I understand that the Certified Athletic Trainer (ATC) is contracted by the school to provide sports medicine services for the school's student-athletes. I hereby give consent for an ATC 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: administering 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, or the athlete's parent/guardian. The Athletic Trainer and/or other 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 for any athletic injury assessment for the athlete will be confidentially maintained in the files of the athletic training room, athletics office or school nurse's office.

I hereby authorize the Athletic Trainer and/or other sports medicine 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, Athletic Director of the school, the school nurse, any treating healthcare provider and/or consulting concussion management specialist.

I understand that there is no charge for me for the above listed athletic training services. If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the provider of his/her choice.

Injured athletes that have been evaluated and/or treated by a physician must submit written clearance from that physician to the Athletics Office/ Athletic Trainer prior to the athlete being permitted to resume activity. In circumstances where an athlete has been removed from play because of a suspected head injury or concussion, the athlete will not be permitted to return to play until the athlete is evaluated by a licensed health care provider, receives medical clearance and written authorization from that provider. This Authorization shall remain in effect for one calendar year beginning with the date set forth below.

Parent/Guardian Name \_\_\_\_\_ Signature \_\_\_\_\_ Date \_\_\_\_\_

Student Athlete Name \_\_\_\_\_ Signature \_\_\_\_\_

### **Pre-Participation Head Injury/Concussion Reporting:**

Has student ever experienced a traumatic head injury (a blow to the head)? Yes No If yes, when?

Has student ever received medical attention for a head injury? Yes No If yes, when?

If yes, please describe the circumstances:

Duration of symptoms (headache, difficulty concentrating, fatigue) for most recent concussion: