

SPORTS MEDICINE

Wisconsin

CONSENT TO ATHLETIC TRAINER SERVICES

I hereby consent to the provision of Athletic Trainer Services for my minor child,
_____ by Certified Athletic Trainers of the
Ascension Sports Medicine Wisconsin Department.

I understand these Athletic Trainer Services consist of evaluation of potential injury, recommendations for treatment up to and including emergency medical treatment, and provision of appropriate treatment (exercises, massage, whirlpool, heat or cold, taping and/or splinting of affected areas, use of protective devices).

I understand the Certified Athletic Trainers also advise coaching staff when it is necessary to restrict or limit the participation of my child in athletic activities including practices and official events.

I understand and agree that I am responsible for seeking follow-up care with my own physician or other provider for my child in the event he or she is injured during a sporting event and requires additional medical attention.

I have read and understand the contents of this consent, understand that if I had questions I could contact Kerrie Linsmeyer (920)716-6360, and my questions have been answered to my satisfaction.

I authorize and consent to my minor child's receipt of services from Certified Athletic Trainers of the Ascension Sports Medicine Wisconsin Department.

Parent/Legal Guardian

Date

Ascension Sports Medicine Department
Fox Valley
1531 South Madison Street
4th Floor Orthopedics
Appleton, Wisconsin 54915