RUSSELL MEDICAL CENTER SPORTS MEDICINE
CONSENT FOR TREATMENT, INFORMATION AUTHORIZATION, AND EMERGENCY CONTACT

Consent for treatment

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I consent to appropriate care and treatment provided by the athletic training staff of Russell Medical Center and its authorized representatives.

Student signature ________________________ Date________________

Authorization for release of information

I authorize the athletic training staff of Russell Medical Center to release medical information to coaches, athletic officials, school officials, insurance companies, and others as deemed necessary and as it relates to my athletic activities for the purpose of assessing the appropriateness of my participation in athletic events and treatment for any injuries or conditions that might effect my participation.

Student signature ________________________ Date______________

♦Authorized student representative ______________________________

♦Authority of representative_____________ _____________________

***If the student is less than 14 years of age or unable to consent, a parent or legal guardian must sign for him/her.**

****This authorization expires one calendar year from date of signing.**

Emergency Information

Athlete's name_________________________ Birthday _______ Grade_____

Parents' names____

Social Security # ________________ Sport/s ______________

Insurance company and contract number_____________________

Local phone________________ Parent's daytime/cell phone_______________

Emergency contact_______________________________Phone_______________

(other than parents)

Relation_________________ Family physician______________________

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