**Permission to Treat, Consent & Authorization for Release of Medical**

**Records, and Acceptance of Risk Form**

**Student Athlete Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERMISSION FOR MEDICAL TREATMENT**

Permission is hereby granted to the Steese Immediate Care professional medical staff when the high school’s Head Trainer is unavailable, and other trained medical professionals during emergencies to proceed with any medical treatment, either minor or emergency, deemed necessary in the event that the above named student-athlete sustains an injury/illness during participation in interscholastic athletics for high school sports. This permission for medical treatment covers the period of the entire school year 2016-2017 terms through July 31, 2017 for all games, practices, activities, events, etc. Permission is also hereby granted to the high school sports Team Physician, and medical professionals to proceed with minor or emergency medical or surgical treatment for the previously named student-athlete. I understand that every effort will be made by the physician/medical professional to contact me prior to treatment.

**CONSENT & AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

Permission is hereby granted to the Steese Immediate Care professional medical staff to examine medical records concerning examination or treatment received by the above named student-athlete for the express purpose of evaluating a medical emergency or the medical or physical fitness for participation in, or continued participation in interscholastic athletics for the student-athlete’s school. Permission is also granted to furnish the Steese Immediate Care professional medical staff with any reports or copies of the student athlete’s medical records that the medical professional may request. I understand that these medical records may be shared with the athlete, his/her legal guardians/parents, other medical providers and WVHS Athletic Trainers, Coaches, Athletic Director, and School Nurse in order to provide them with recommendations for, and to provide medical treatment to the student-athlete. I understand that information released may no longer be protected by state and federal privacy laws and regulations.

**ACCEPTANCE OF RISK**

We are aware of, and accept, the risk of injury associated with participation in interscholastic athletics for high school sports. As a student-athlete, I will do my part to reduce the risk of injury by keeping myself in the best possible physical and mental condition and will follow the advice of the Team Physician, Athletic Trainer, and Coach concerning the prevention, evaluation, treatment, and rehabilitation of athletic injuries. I agree to be honest in my participation in athletics at WVHS and to report any and all illegal activities to the appropriate authority.

**Student-Athlete Signature & Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_\_/\_\_\_\_

**Parent/Guardian Signature & Date**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_

**Parent/Guardian Contact Numbers: Work** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home** \_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell** \_\_\_\_\_\_\_\_\_\_\_\_

\*Please notify Trainer immediately if contact numbers change.