bellinhealth

Revised 10/22/19 Rv 10/11/22 Revised 9/22/23

CONSEN CONSEN

TREATMENT CONSENT – STUDENT ATHLETE

Full Student Name □ emancipated minor
(First, Middle, and Last)

Date of Birth

Address

City, State, Zip

Parent's Phone Number

Name of School attended by Student

Anticipated Date of Graduation (month/year)

CONSENT TO TREATMENT: As a result of athletic/school participation, treatment may be necessary for the student. I give consent to Bellin Health Licensed Athletic Trainers, Physical Therapists, and Physicians to evaluate, treat, and manage any injuries, and activate emergency care as indicated within their scope of practice for my child named above. I also give consent to Bellin Health Licensed Athletic Trainers, Physical Therapists, and Certified Strength and Conditioning Specialists to instruct my above named son/daughter in performance enhancing or corrective exercise techniques or programs.

EXPIRATION DATE OF THIS CONSENT: If not previously revoked, this consent will expire on September 1 of the subsequent academic year, or upon graduation or departure from the school system, whichever occurs first.

I have had an opportunity to review and understand the content of this consent form. By signing this form, I understand and agree with the content.

Signature of person legally authorized to sign for minor student, or signature of the student if his/her age is 18 or greater (date/time)

If other, indicate relationship:
- □ Custodial Parent
- □ Court Appointed Guardian
- □ Health Care Agent
- □ Personal Representative

Printed name of person signing above