optim sports medicine

PATIENT FOCUSED • PHYSICIAN OWNED

PARENT/GUARDIAN CONSENT & RELEASE FORM

In order to provide the best possible medical care for your child, a medical record will be established for him/her. If your child should become injured while playing sports, this form will provide important information to coaches and medical personnel. Please complete and sign as indicated.

EMERGENCY CONTACT INFORMATION

Student's Name (Legal)_____,_____,_____
LAST FIRST MI

Student's Preferred Name _____**Social Security #**_____-_____-_____

D.O.B._____/_____/_____ **Current Class** (circle one): 6th 7th 8th Fr So Jr Sr **HS Graduation Year: 20**_____

Address: _____, **GA** _____
Street City Zip

Student's Home Phone #:(_____**)** _____-_____ **Student's Cell Phone #:(**_____**)** _____-_____

Child Lives With: ____ Father _____ Mother _____Both _____Other: _____

Father/Guardian's Name: _____ Employer: _____

Father/Guardian's Cell Phone #: (_____) _____-_____ Work Phone # (_____) _____-_____ext_____

Mother/Guardian's Name: _____ Employer: _____

Mother/Guardian's Cell Phone #: (_____) _____-_____ Work Phone # (_____) _____-_____ext_____

Parent/Guardian Contact E-Mail Address: _____

Emergency Contact (must be 21 or older): _____Relationship:_____

Contact Home Phone #: (_____) _____-_____ Contact Cell Phone # (_____) _____-_____ext_____

Primary Physician: _____ Office Phone # (_____)_____-_____ext _____

INSURANCE INFORMATION

Primary Insurance Co: _____ **Name of Policy Holder:**_____

Policy #: _____ **Group #:** _____

Customer Service Phone #: _____ **ext** _____

*****PLEASE BE AWARE OF THE FOLLOWING WHEN CARING FOR MY CHILD*****

Medical Conditions: _____

Allergies: _____

Medications & Condition: _____

PERMISSION FOR AUTHORIZATION TO TREAT IN PARENT'S ABSENCE

*I give permission for school representatives to authorize medical treatment for my child in my absence. This may include, but is not limited to, activation of emergency services, emergency room procedures, and injury/illness evaluation treatment by certified athletic trainers at away competitions.

Print Parent Name:_____ **Parent Signature:**_____

Date: _____/_____/_____

Please complete/sign/date every line (if applicable) in order for your student athlete to be eligible to participate.

ATHLETIC TRAINING & COMPETITION PARTICIPATION: **Parental Consent and Insurance Information.**

Warning: Although participation in supervised interscholastic athletics and school activities may be one of the least hazardous in which students will engage in or out of school, **BY ITS NATURE, PARTICIPATION IN INTERSCHOLASTIC ATHLETICS AND SCHOOL ACTIVITIES INCLUDES RISK OF INJURY, WHICH MAY RANGE IN SEVERITY FROM MINOR TO LONG-TERM CATASTROPHIC INJURY, INCLUDING PERMANENT PARALYSIS FROM THE NECK DOWN OR DEATH.** Although serious injuries are not common in supervised school athletic programs or the school setting, it is possible only to minimize, not eliminate, risk.

Students can and do have responsibility to help reduce the potential for injury. **STUDENTS AND PLAYERS MUST OBEY ALL SAFETY RULES, REPORT ALL PHYSICAL PROBLEMS TO THEIR TEACHERS/COACHES, FOLLOW A PROPER CONDITIONING PROGRAM, AND INSPECT THEIR EQUIPMENT DAILY.**

By signing this consent form, you acknowledge that you have read and understand this warning. **PARENTS OR STUDENTS WHO DO NOT WISH TO ACCEPT THE RISKS DESCRIBED IN THIS WARNING SHOULD NOT SIGN THE FORM.**

I/We hereby give consent for my/our child to:

1. Compete in athletics in the Georgia High School Association.
2. Accompany any school team/activity on any of its local or out-of-town trips.
3. Verify that the information on this form is correct and understand that any false information may result in my son/daughter being declared ineligible to participate.

I further acknowledge and consent to the Internet storage and delivery of this information by Optim Sports Medicine and its affiliated vendors to medical providers, as appropriate.

This acknowledgement of risk and consent to allow participation shall remain in effect until revoked in writing.

Authorization to Release Medical Information

I, being of lawful age, hereby authorize and consent to having Optim Sports Medicine Program Athletic Trainers and/or their consulting physician(s) provide any requested medical information to other physicians, healthcare providers, high school coaches or school administration, intercollegiate teams, professional teams, scouts, recruiters, or athletic trainers that directly pertains to my participation at _____. Said authorization to release medical information will include, but is not limited to, information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in activities at said school or athletic organization.

I understand that I may revoke this authorization by providing written notice to Optim Sports Medicine. I also understand that I am authorizing access to the student's medical records and patient identifiable information by executed this release.

This authorization shall be valid for one (1) year commencing on the effective date executed below. I understand that the release of my medical information is being carried out with my consent and so assume full responsibility.

MEDICAL CONSENT TO TREAT

I hereby grant parental consent to Optim Sports Medicine for assessment/treatment of any injuries my child may suffer during the school year in the course of athletic training or competition.

I give permission for school officials, chaperones, or representatives of Optim Sports Medicine overseeing the athletic training or competition in which my child is participating to seek medical aid and render first aid if such attention is necessary, at the sole discretion of such individual. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by school officials to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery for my child. I agree to be responsible for all medical expenses incurred in connection therewith. In the event the school incurs expenses for medical treatment, I agree to reimburse school in full.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS READ AND UNDERSTOOD THE ABOVE.

_____ _____

Parent/Guardian Signature **Date**

_____ _____

Print Name **Relationship to Student**