A Division of Hillsboro Area Hospital
TEAMWORK REHAB
Athletic Training
Speech, Occupational & Physical Therapy

AUTHORIZATION FOR ATHLETIC TRAINING SERVICES AND CONSENT FOR TREATMENT

I, the undersigned, am the parent/legal guardian of, _____, minor and student-athlete at
(Student athlete name-please print)
_____ who plans on participating in _____
(Name of school) (Sport(s))

I understand that Teamwork Rehab, a department of Hillsboro Area Hospital, ("TWR") is contracted by the school to provide sports medicine services for the school's athletes. I hereby give consent for a Certified Athletic Trainer from TWR to provide sports medicine services for the above minor. Sports medicine services include, but are not limited to: administrating first aid for athletic injuries, providing initial treatment and management of acute injuries, and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Athletic Trainer will perform only those procedures that are within their training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. I understand that a written report of any athletic injury assessment for the athlete will be confidentially maintained in the files of the Athletic trainer.

I, hereby authorize the Athletic Trainer(s) to provide services to the above-named athlete and to disclose information about the athlete's injury assessments and post-injury status. I understand such disclosures will be done, as needed, with the involved coaching staff, Athletic Director of the school, the school nurse, any treating healthcare provider and/or consulting concussion management specialist.

I understand that there is **NO CHARGE** to me for the above listed athletic training services. If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician or provider of his/her choice.

Injured athletes that have been evaluated and/or treated by a physician **must submit** written clearance from that physician to the Athletic Trainer/coach prior to the athlete being permitted to resume activity. In circumstances where an athlete has been removed from play because of a suspected head injury or concussion, the athlete will not be permitted to return to play until the athlete is evaluated by a healthcare provider, receives medical clearance and written authorization from that provider.

This Authorization shall remain in effect for one year beginning with the date set forth below.

Parent/Guardian Name (print) _____ Date_____
Parent/Guardian Signature _____ **Relationship to student athlete**_____
Cell/work phone_____ **Home phone**_____
Home Address _____
Student Athlete Name_____ Sex_____ Grade_____ Date of Birth _____
Allergies_____
Current Medications (ie asthma inhalers, epi-pen, etc)_____
Physical impairments_____
Other pertinent medical history (surgeries, diabetes, seizures, heart conditions, etc)_____
_____
_____
Physician Name_____Physician Phone _____

Pre-Participation Head Injury/Concussion Reporting:

Has student ever experienced a traumatic head injury (a blow to the head)? YES ___ NO ___ If yes, when? Dates (month/year)_____
Has student ever received medical attention for a head injury? Yes ___ No ___ If yes, when? Dates (month/year) _____
If yes, please describe the circumstances: _____
Was student diagnosed with a concussion? Yes ___ No ___ If yes, when? Dates (month/year) _____
Duration of symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion: _____

_____ _____
Student Athlete Signature **Parent/Guardian Signature**

Statement Acknowledging Receipt of Education and Responsibility to Report Signs/Symptoms of Concussion:

I, _____of _____ School hereby acknowledge having received education about the signs, symptoms and risk of sports related concussion. I also acknowledge my responsibility to report to the school, athletic trainer, coaches, and my parent(s)/guardian(s) any signs/symptoms of a concussion.

_____ _____
Signature and Printed Name of student athlete **Date**

I, the parent/guardian of the student athlete named above, hereby acknowledge having received education about the signs/symptoms and risks of sport related concussion and acknowledge my responsibility to report to the school athletic trainer, and coaches, any signs/symptoms of a concussion in the above minor.

_____ _____ _____
Signature and Printed Name of parent/guardian **Date** Rev. 05/15