# Consent for Evaluation and Treatment

***This form is valid for the current school year. You do not need to turn in a form for each sport.**

Fall Sport: _____Winter Sport:_____ Spring Sport:_____

Athlete: _____ Date of Birth:_____

(Please print and use blue or black ink)

I hereby understand the provided policy and procedure brochure and give permission for my son/daughter to be evaluated and treated by Worthington Kilbourne High School Team Physicians and Athletic Training Staff with the guidance of the team physician. I understand that I will be notified any time my child is evaluated by the team physician. (A written evaluation is made anytime the team physician sees your child.) If you do not receive a copy of this evaluation, please notify us at 614-450-6517. I authorize the treating physician, including the team physician, to disclose information regarding any injuries that my son/daughter might receive during the course of the season to any member of the sports medicine or coaching staff. I also understand that signing this consent form does not restrict me in any way from consulting with my own physician as well.

Parent/Guardian Full Name/Names:_____

Parent/Guardian Signature:_____ Date :_____

Home #:_____ Work #: _____ Cell #:_____

Email address:_____

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**Non-Consent: Do NOT sign this portion if you have signed the above section.**

I prefer to make all decisions regarding an injury/condition sustained by my son/daughter. All medical care with the exception of first aid, will be my responsibility.

Parent/Guardian Signature: _____ Date: _____