HAMILTON SPORTS MEDICINE

Athlete's Name:________________________ **Sport(s)**___________________________
PLEASE PRINT

School Year: 2016-2017 **Grade**______________________________

PLEASE READ THE FOLLOWING CONSENT FORMS CAREFULLY:
(If you are under 18 years of age, your parents must also sign.)
The basic content of each is:

- **Part I**. Medical consent: Allows Hamilton Sports Medicine (HSM) and physicians to treat any injury or illness incurred by you while at (name of school) Dalton High School.
- **Part II**. Release of Information: Allows HSM and those associated with HSM to release and/or receive information concerning your injuries to/from (name of school) Dalton High School and its coaching staff, administrators, insurance carriers, and/or medical personnel and other medical facilities.

MEDICAL CONSENT - Part I

I hereby grant permission to Hamilton Sports Medicine (HSM) and team physicians, or other physicians designated by the above school to provide me with any medical care or surgical care that they deem reasonably necessary to my health and well being as a result of injuries or other medical conditions occurring as the result of or during athletic activities.

I further authorize the athletic trainers of HSM who are under the direction and guidance of a physician to provide me with any preventive, first -aid, rehabilitative or emergency treatment they deem reasonably necessary to my health and well being as a result of injuries or other medical conditions occurring as the result of or during athletic activities.

If reasonably necessary to provide the care described in the preceding two paragraphs, I grant permission to HSM and/or school officials to seek necessary treatment at an accredited hospital.

_____________________ ________
ATHLETE'S SIGNATURE DATE
(If athlete is 18 years of age)

I hereby grant permission on behalf of my minor son or daughter or my ward.

_____________________ ________
PARENT OR GUARDIAN DATE

AUTHORIZATION FOR RELEASE OF INFORMATION- Part II

A. I hereby authorize Hamilton Sports Medicine (HSM) to release medical information to team physicians, said school coaching staff, and/or its administrators, and insurance carriers any information concerning illness or injury relative to my past, present, or future participation in athletics at said school.

B. I hereby authorize any medical facility, physician, or medical personnel whom has attended to me to disclose when requested by HSM any and all information regarding my illness or injury, medical history, consultation, diagnostic tests, treatment, recommendation, and copies of all hospital or medical records.

A photostatic copy of this authorization shall be considered valid and effective as the original.

_____________________ ________
ATHLETE'S SIGNATURE DATE
(If the athlete is 18 years of age)

I hereby grant permission on behalf of my minor son or daughter or my ward.

_____________________ ________
PARENT OR GUARDIAN DATE