Clarinda High School Medical Consent to Treat Form

Clarinda Regional Health Center Sports Medicine Providers ("CRHC Sports Med Providers") are contracted to provide sports medicine coverage to Clarinda High School, which services include the prevention, emergency care, first aid, treatment, and rehabilitation of **Athletic Related Injures** using certain physical modalities (i.e. methods of treatment). The Athletic Trainer and/or sports medicine clinical staff 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. "Athletic Related Injuries" is defined as the types of musculoskeletal injury or common illness and conditions, incurred by student-athletes, which prevent or limit participation in sports or recreation and which CRHC Sports Med Providers are educated to treat or refer.

I, the undersigned, certify that I am the parent or legal guardian of the child or children listed below and that I am authorized to provide informed consent for any Athletic Training Services provided to the applicable child below by CRHC Sports Med Providers. I hereby consent to the following (please initial where giving consent):

_____ I hereby give consent for a Certified Athletic Trainer and/or other CRHC sports medicine clinical staff to provide sports medicine services for the below minor/s.

_____ CRHC Medical Providers may contact or otherwise communicate with other health care providers (including, without limitation, other CRHC Medical Providers) as needed for purposes of providing Athletic Training Services.

_____ I hereby give consent that data relating to athletics can be used to track progression in recovery and aid in progressing the safety of student-athletes.

The above consents are intended to cover any Athletic Related Injury sustained in connection with any Clarinda High School competition or practice, whether on or off Clarinda High School property. I understand the nature of the athletic training services which I have consented to above, and I acknowledge that no guarantees have been made to me or my child as to the results thereof.

I hereby specifically release and agree to indemnify and hold harmless Clarinda High School, its board members, employees, contractors, and agents (including, without limitation, CRHC Sports Med Providers) from any and all claims associated with taking or referring from taking any action in accordance with the above instructions, including, without limitation: giving, obtaining, or refraining from giving or obtaining, Athletic Training services.

I acknowledge that I am financially responsible for the payment of any medication, medical or surgical care, treatment or procedures provided to my child. 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 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 sports season beginning with the date set forth below or I provide written notice to Clarinda High School and CRHC Medical Providers that I am revoking the instructions provided in this document.

_____	_____
Parent/ Guardian Printed Name	Child Printed Name and Signature
_____	_____
Parent/ Guardian Signature and Date	Child Printed Name and Signature

Clarinda Regional Health Center

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Student's Name: _____ Date of Birth: _____

Student's Address: _____ City: _____

Parent (Guardian) Name: _____

Home Phone: _____

Father: Work Phone_____ Cell: _____

Mother: Work Phone _____ Cell: _____

In case of emergency and the absence of parent/guardian, please list two people you recommend we call:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

List any known allergies: _____

List any medications student is taking and why: _____

List any physical disabilities: _____

Additional Comments: _____

_____

Name of Medical Insurance Company or Plan: _____

Policy Number(s): _____ Group Number(s): _____

Health Maintenance Organization (HMO)? ____Yes ____ No

If yes, what is your primary care facility: _____

Primary Physician: _____ Phone: _____

**** If not signed, consent to treatment is WAIVED unless deemed a medical emergency****

"We are dedicated to providing health and wellness to our communities with Compassionate, Respectful, Holistic, and Collaborative care."