

Wamego Health Center
711 Genn Drive
Wamego, KS 66547

Print Name _____ Sport _____

To be read and signed by the Student-Athlete and the Parent/Guardian if the Student/Athlete is under 18 years old.

CONSENT TO TREATMENT AND DISCLOSURE OF INFORMATION

Consent is hereby granted by the undersigned to Wamego Health Center, including each of their sports medicine staff and health care professionals, to proceed with any physical examination that the professional staff considers to be necessary for the student-athlete named below. This physical examination can occur during an actual sports event or during any sports medicine clinic hosted at the school. I understand that Wamego Health Center is only providing limited physical examinations and is under no obligation to provide medical services to me, and I hereby release and agree to indemnify, defend and hold Wamego Health Center harmless in the event their representatives fail to do so.

Authorization and consent is hereby granted by the undersigned to Wamego Health Center, including their respective sports medicine staff and health care professionals, to obtain and release health information and records for treatment, payment and operations purposes, including for the purpose of processing insurance claims.

I understand and agree that information, including information about my injury/condition may be disclosed to the staff and personnel of Wamego Health Center, on an as needed basis in connection with the services to which I am consenting, and in relation to my participation in any physical sports activity at Wamego High School.

This Consent to Treatment and Disclosure of Information is a required condition for participation in the sports medicine program and shall remain valid until revoked in writing.

Signature of Student-Athlete

Birthdate (mm/dd/yy)

Age

Date (mm/dd/yy)

Name of Parent/Legal Guardian (PRINT)

Signature of parent/Guardian

Date (mm/dd/yy)