ST. VINCENT SPORTS MEDICINE
Consent for Athletic Training Services

Student Name: (full legal name) ____

Address: ____

City: ______________________________ State: __________________ Zip: ____________

Telephone: ___________________ Cell: __________________ Email: _______________________________

Birth Date: ____________________ Age: ___________

If under age 18, please provide legal guardian/parent name(s): _______________________________________

Emergency Contact Name: ____

Emergency Contact Phone: __________________ Cell: __________________ Other: ____________________

I, ____, the parent or legal guardian for the Student listed above, do hereby consent to the Student receiving athletic training services from St. Vincent Sports Medicine. I understand that during the course of these services certain health information related to Student's athletic training services may be used and/or disclosed for treatment, payment or healthcare operations purposes, or as otherwise required by law.

I further consent to certain health information being disclosed to school personnel, including but not limited to, coaches, school administration, and/or staff, as necessary.

I understand this consent is subject to my revocation at any time, except to the extent that action has been taken in reliance on this consent. Otherwise, this consent shall expire at the end of the school year or the Student's current athletic season, whichever is later.

____
Parent /Legal Guardian Signature

____
Date