Southern Therapy Services Sports Medicine
Consent To Treat

I hereby authorize the Certified Athletic Trainer and sports medicine staff acting on behalf of the Carroll County School System to evaluate and treat any injury/illness that occurs as a result of my participation in athletics. This includes any and all reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses. I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care I may not return to participation until I have been given permission by a Physician and/or Certified Athletic Trainer. This may occur during or at the conclusion of medical treatment. The overseeing physicians and athletic trainer have the FINAL authority regarding participation status following injury/illness. I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform my Head Coach and the Certified Athletic Trainer. I also agree to adhere to the established injury management guidelines including rehabilitation and reassessment before I am released to return to full participation.

This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

_____
Print Name

_____
Signature

_____
Date

_____
Parent/Guardian Signature (if student-athlete is under 18 years of age)

Authorization to Disclose Private Health Information

I grant permission to the Certified Athletic Trainer to disclose my Personal Health Information (written and/or verbal), when requested to do so, for the purposes of health care treatment, or for any other purpose which is permitted or required by law. Personal Health Information includes but is not limited to: information involving the nature and treatment of an injury/illness, medical history, insurance coverage and copies of all hospital and medical records. This information will be released ONLY for the purposes of further treatment (referrals to specialists or other health care providers), disclosure of participation status to your team's coaches for your health and safety. In order to maintain continuity of care and provide participation status updates to athletic department personnel, I hereby authorize the Certified Athletic Trainer to disclose injuries/illness contained in my student-athlete medical file, including medical conditions(s), treatment and rehabilitation status, and participation restrictions to the following entities:

a) Physicians: Ortho West
b) _____ High School Athletic Administration
c) Parents/Guardians: (names)_____

This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

_____
Print Name

_____
Signature

_____
Date

_____
Parent/Guardian Signature (if student-athlete is under 18 years of age)