

Acupuncture & Eastern Medicine • Ayurveda • Chiropractic • Diagnostic Imaging • Human Performance
Joint Rejuvenation • Massage Therapy • Sports Medicine • Tactical Sports Medicine

WCHS/SCU Consent for Medical Treatment

I, the undersigned, give the Sports Medicine Team of Whittier Christian High School/ Southern California University (SCU) including; Certified Chiropractic Sports Physicians, Certified Athletic Trainers, Medical Doctors, Physician Assistants, etc. consent to obtain medical history, perform or get access to pre-participation medical exams, and perform injury evaluations and treat any injuries I may obtain through my participation in sanctioned athletic activities at Whittier Christian High. I understand that the SCU Sports Medicine Staff at Whittier Christian may only provide services that fall within their training/credentialing/professional scope of practice in regards to the prevention, evaluation, treatment, and rehabilitation of athletic injuries. If further or advanced medical care is warranted, I understand that I will be referred for care to advanced medical specialists. I further understand that, if I sustain an injury or become ill, I am to notify the SCU Sports Medicine Staff as soon as possible; furthermore, if I should seek outside medical treatment of my own volition, my return to practice/competition/play will be at the discretion and **ONLY AFTER CLEARANCE** by SCU Sports Medicine Staff.

Authorization to Release Medical Information (HIPAA)

I, the undersigned, give consent for Whittier Christian/SCU Sports Medicine Staff to release information to my coaches, team physicians, emergency medical personnel, and insurance company for the purpose of communication of nature and status of injury as well as treatment and for insurance claims purposes. No member of the Whittier Christian/SCU Sports Medicine Department will release my medical records to third parties not named above without my consent, unless such release is required or permitted under this (or other WC) agreement, or application by law. This release is valid for the period of two years unless revoked by me in writing.

I understand, am informed that, as in any practice of medicine or rehab there are risks and some risk to treatment, not limited to sprains/strains, abrasions, bruising, etc. I do not expect the Whittier Christian/SCU Sports Medicine Staff to explain all risks. I wish to rely on the Whittier Christian/SCU Sports Medicine Staff to exercise their best judgement during the course of rehab or treatment based upon the facts then known, and in my best interest.

BY SIGNING THIS FORM, I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENTS. WITH MY SIGNATURE BELOW, I GRANT PERMISSION TO THE WHITTIER CHRISTIAN/SCU SPORTS MEDICINE STAFF TO TREAT ALL ILLNESSES/INJURIES SUSTAINED DURING MY SON/DAUGHTER’S ATHLETIC CAREER AT WHITTIER CHRISTIAN, ALONG WITH THE RIGHT TO RELEASE INJURY RECORDS FOR MEDICAL PURPOSES. (HIPAA and FERPA).

STUDENT NAME	Student-Athlete Signature	Date
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PARENT / GARDIAN NAME	Parent/Guardian Signature	Date
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