

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_give permission for my child, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (student athlete’s name) to be assessed by the Cincinnati Children’s Hospital Medical Center Athletic Trainer. The injuries will be assessed at

Cincinnati Christian Schools and all facilities used by the school for activity. All Injury assessments will be conducted under the guidelines of the protocols used by Cincinnati Children’s Hospital Division of Sports medicine. Non-emergency athletic injuries will be referred to a physician within 7 days if the injury is not on track for improvement.

Parent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician/Athletic Trainer Assessment Permission