

**Hendricks Regional Health  
Sports Medicine Program  
Parental Consent, Acknowledgment, and Release Form**

**(Must be completed by parent/guardian; where divorce or separation, parent with legal custody must sign)**

Student Name: \_\_\_\_\_ Gender: M F Age: \_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Sports Participating in \_\_\_\_\_

Parents email address: \_\_\_\_\_

If you prefer not to receive information concerning sports medicine services via mail/email please check the box.

**CONSENT**

**As parent or legal guardian of the above named student-athlete, my signature below grants consent for Hendricks Regional Health's (HRH) Licensed Athletic Trainer (LAT) and/or attending physician to perform: (Please initial on the line to the left acknowledging you have read and understand the following)**

\_\_\_\_\_ 1. Injury prevention, evaluation, and/or treatment during school athletic activities designated by the school, including pre-participation physicals

\_\_\_\_\_ 2. Administration of over the counter medications for use in first aide management and strains/sprains, limited to topical applications (i.e., bacitracin ointment, hydrocortisone cream, anti-fungal creams, etc.) and oral antacids (i.e., Tums, Roloids, etc.).

**Parent/Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**ACKNOWLEDGEMENT and RELEASE**

**Please initial in the line to the left acknowledging you have read and understand the following:**

\_\_\_\_\_ 1. I acknowledge that my son/daughter knows the risks involved in athletic participation, understand that serious injury, and even death is possible as a result of such participation and I choose to accept any and all responsibility for his/her safety and welfare while participating in athletics.

\_\_\_\_\_ 2. With full understanding of the risks involved, I release and hold harmless the athletic trainers, physicians, and Hendricks Regional Health (HRH) of any and all responsibility and liability for any injury or claim resulting from such athletic participation and agree to take no legal action against HRH because of any accident or mishap involving the athletic participation of my son/daughter.

\_\_\_\_\_ 3. All information regarding the medical condition of an athlete is considered confidential. However, pertinent information may be shared with the coaching staff, athletic training/medical staff, athletic department administration, school nurse, and school corporation administration to facilitate proper care of the athlete. No further release of medical information will be made without written consent of the athlete and his/her parent/guardian.

**I HAVE READ THIS CAREFULLY AND KNOW IT CONTAINS A RELEASE.** I will be provided a copy of the HRH Joint Notice of Privacy Policies, upon my request

**Parent/Guardian Signature:** \_\_\_\_\_ **Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Emergency Contact Information Sheet**

**This information will be kept CONFIDENTIAL and will only be used to assist in the event of an emergency with your son/daughter.**

Mother's Name: \_\_\_\_\_ Address \_\_\_\_\_ City \_\_\_\_\_

State: \_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_ Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ ext. \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Emergency Contact (Outside of Home):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ ext. \_\_\_\_\_ Cell #: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ ext. \_\_\_\_\_ Cell #: \_\_\_\_\_

**Pertinent Medical Information:**

Insurance Company: \_\_\_\_\_ Policy No: \_\_\_\_\_ Group/Plan: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone No: \_\_\_\_\_

**Medical Conditions – please list all**

A. Known Allergies: \_\_\_\_\_

B. Known medical conditions, [i.e., cardiac, asthma, special conditions (including, but not limited to sickle cell, diabetes, missing organs, etc.)]: \_\_\_\_\_

C. Previous Surgeries or Broken Bones: \_\_\_\_\_

D. Current Medications (long-term medications such as asthma inhalers, insulin, Ritalin, etc. to include dosage): \_\_\_\_\_

E. Other: \_\_\_\_\_