



**MEDICAL CONSENT TO TREAT  
STATESBORO HIGH SCHOOL  
2019-2020**

Student Name \_\_\_\_\_

The undersigned grants the representative from Optim Sports Medicine Center and its employee's parental consent for your child's pre-participation screening and assessment/treatment of your child's injuries that he/she may suffer during the school year.

I give permission for the school official, chaperone, or representative of the Optim Sports Medicine Center, involved in the activity with my child, to seek medical aid, render first aid if such attention is necessary in the sole discretion of said person involved. In case of emergency and when I cannot be immediately reached by telephone or otherwise, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, and order injections, anesthesia, or surgery for my child. I agree to be responsible for all medical expenses incurred in connection therewith. In the event the School incurs expenses for medical treatment, then and in that event I agree to reimburse said institution in full.

**THE UNDERSIGNED CERTIFIES THAT HE/SHE READ AND UNDERSTANDS THE ABOVE.**

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

**CONSENT FOR A PRE-PARTICIPATION EVALUATION (PPE)  
(\*Must be signed if participating in Optim-provided Spring Physicals\*)**

I hereby authorize and consent to having Dr. Robert Wagner and Optim Sports Medicine Center Athletic Trainers and/or their consulting physician(s)/physician assistant(s) perform a Pre-Participation Evaluation (PPE) on my child for the 2019-2020 school year. I understand that this PPE is a health screening and is not intended to take the place of the physical exam that can be performed by a physician. I understand that the scope of this PPE (medical history, blood pressure/pulse screen, and heart/lung auscultation) **WILL NOT IDENTIFY** many of the medical problems known to be associated with sudden death in athletes. Some of those medical problems include but are not necessarily limited to cardiac abnormalities, pulmonary abnormalities, aneurysms, and/or sickle cell trait.

I hereby fully and forever release and discharge Statesboro High School, Dr. Robert Wagner, Optim Sports Medicine Center., its subsidiaries and affiliated corporations, and their respective directors, trustees, officers, employees and agents and my physician(s) or any other person participating in my care from any and all claims, demands, damages, rights of acting or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from or arising out of the completion of this PPE.

I understand that this PPE is being carried out with my consent and so assume full responsibility for the limitations of this PPE in detecting many of the health problems associated with sudden death in athletes.

\_\_\_\_\_  
**Parent/Guardian Signature**

\_\_\_\_\_  
**Date**

*Please complete/sign/date every line (if applicable) in order for your student athlete to be eligible to participate.*