

BENTONVILLE SPORTS MEDICINE CONSENT TO TREATMENT (OUTSIDE PHYSICIAN)

I,, AM A BENTONVILLE PUBLIC SCHOOLS ATHLETE. BY SIGNING THIS FORM I AM
GIVING MY CONSENT TO BE TREATED BY MEDICAL PERSONNEL NOT EMPLOYED OR AFFILIATED WITH
BENTONVILLE PUBLIC SCHOOLS.
I UNDERSTAND THAT NO PROMISES HAVE BEEN MADE TO ME ABOUT THE RESULTS OF MY TREATMENT OR
SERVICES.
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I HEARBY <u>RELEASE</u> , <u>WAIVE AND DISCHARGE</u> BENTONVILLE PUBLIC SCHOOLS AND ITS EMPLOYEES FROM ANY AND
ALL <u>LIABILITY, CLAIMS, DEMANDS AND ACTIONS</u> ARISING OUT OF OR RELEATED TO BEING TREATED BY MEDICAL
PERSONNEL NOT EMPLOYED BY OR AFFILIATED WITH BENTONVILLE PUBLIC SCHOOLS. THIS INCLUDES ANY LOSS,
DAMAGE, INJURY OR COST THAT MAY BE SUSTAINED BY ME WHILE SEEKING SUCH TREATMENT.
BENTONVILLE PUBLIC SCHOOLS MAY RELEASE MY HEALTH INFORMATION TO OTHER MEDICAL PERSONNEL WHO
MAY TREAT ME. THIS COULD INCLUDE HEALTHCARE PROVIDERS WHO MAY TREAT ME WHOM ARE NOT
AFFILIATED WITH BENTONVILLE PUBLIC SCHOOLS.
ATTEMATED WITH BENTONVILLE FOBLIC SCHOOLS.
THIS FORM WILL EXPIRE <u>1 YEAR</u> FROM TODAY. I WILL BE ASKED TO SIGN THIS FORM AGAIN IF I AM STILL A
BENTONVILLE PUBLIC SCHOOLS ATHLETE IN 1 YEAR.
I PROVE WITH MY SIGNATURE BELOW THAT:
- I HAVE READ AND UNDERSTAND ALL THE FACTS STATED ABOVE
- I HAVE HAD A CHANCE TO ASK QUESTIONS REGARDING THIS FORM
- ALL OF MY QUESTIONS HAVE BEEN ANSWERED
SIGNATUREDATEWITNESS
SIGNATURE OF PARENT OR RESPONSIBLE PARTYDATE
PRINTED NAME (IF NOT PATIENT)