Emory Sports Medicine

Consent to Treat

(Athletes under 18)

To Whom It May Concern,

I, the undersigned, parent/guardian of ____, give permission for my son/daughter to receive medical treatment by Emory Sports Medicine Staff, which includes the team physicians and certified athletic trainers.

Signed,

____
Signature of legal guardian/parent Date

____
Printed Name (legal guardian/parent)/

____
Signature of Athlete Date

Address:

____

____

____

Phone:

Home: (   )_________________

Work: (   )_________________