THE HUGHSTON FOUNDATION, INC. & THE HUGHSTON CLINIC, P.C.

CONSENT TO TREATMENT

Dear Parent/Guardian:

In order to provide the best possible medical care for your child or ward (hereinafter, collectively, "child"), a medical record will be established for him/her. If your child should become injured while playing sports, this record will provide important information about him/her. Please complete and sign as indicated and return to your child's coach. Your signature serves as permission to treat your child until 18 years of age or until he/she has completed activity participation.

THIS INFORMATION MUST BE COMPLETED BEFORE YOUR CHILD CAN BE EVALUATED / TREATED FOR ANY INJURY THAT MAY OCCUR

Athlete Name: _____ D.O.B.____/____/_____

Athlete Address: _____
Street City State Zip

Parent/Guardian Name: _____

Parent/Guardian Address: _____
Street City State Zip

Home Phone:_____Work Phone: _____

Guaranteed contact number - Pager, Cell Phone, etc. _____

INSURANCE INFORMATION

Primary: ***Secondary:***

Company Name:_____Company Name: _____

Policy and/or Group No.: _____ Policy and/or Group No.: _____

ALLERGIES/MEDICAL CONDITIONS

My child's doctor is: _____

My child is currently taking the following medications:_____

_____

My child has the following allergies or medical conditions: _____

_____

PARENTAL CONSENT

The undersigned grants consent to The Hughston Foundation, Inc. and to The Hughston Clinic, P.C., and to their respective employees, for the child listed above to receive an assessment and the treatment of any injuries he/she may suffer during the school year. Injury treatment would include the application of modalities such as cold, heat, electrical muscle stimulation and/or ultrasound if necessary, as well as therapeutic exercises, to safely speed recovery and return to activity.

MEDICAL RELEASE

I, the undersigned, give permission for school officials, chaperons, or representatives of The Hughston Foundation, Inc. and The Hughston Clinic, P.C. involved in the activity with my child to seek medical attention or render first aid if such attention is necessary in the discretion of the said person involved. In case of emergency, and when I cannot immediately be contacted, I give permission to the physician selected by the school officials to hospitalize, secure proper treatment, order injections, anesthesia, or surgery for my child.

ACKNOWLEDGEMENT OF RISK

Both the student and the parent/guardian should read this statement carefully. You should be aware that playing, practicing, conditioning and preparing for participation in any sport can be a dangerous activity involving risks of injury. The dangers and risks of sports participation include, but are not limited to: death, serious neck, head and/or spinal injuries which may result in complete or partial paralysis, brain damage, serious injury to virtually all internal organs, serious injury to virtually all bones, joints, ligaments, tendons, and other aspects of the body, general health and well being. Because of the dangers of participating in sports, the student should recognize the importance of following coaches' instructions regarding playing techniques, training, and other teams' rules and obey such instruction.

ASSUMPTION OF RESPONSIBILITY

It is my desire that my child participate in such athletic activities for which the within Consent to Treatment, Medical Release and Acknowledgement of Risk is being given by me as the parent or legal guardian of such child and as a precondition to my child's participation in such athletic activities. I fully understand the importance, consequences and affects of the within Consent to Treatment, Medical Release and Acknowledgement of Risk that I am entering into on behalf of myself and on behalf of my child, I have fully disclosed any medications, allergies or medical conditions that my child may have, and I assume full responsibility for any action taken in reliance upon the provisions hereof.

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

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

_____

Print Parent's/Guardian's Name

_____ _____

STUDENT ATHLETE DATE

_____

Print Student Athlete's Name

The Hughston Foundation, Inc. & The Hughston Clinic, P.C.

Authorization to Release Medical Information

I,_____, being the parent/legal guardian of _____ and residing at _____ _____, do hereby authorize and consent to having The Hughston Foundation, Inc.'s and/or The Hughston Clinic, P.C.'s athletic trainers and/or consulting physician(s) provide any requested medical information to other physicians, other healthcare providers, the high school coaches or school administration, intercollegiate teams, professional teams, their scouts, recruiters, or athletic trainers which directly pertains to such child's or ward's (collectively "child") athletic participation at _____. Said Authorization To Release Medical Information will include, but is not necessarily limited to information concerning illnesses, injuries, treatments, hospitalizations, examinations, X-rays, or other forms of diagnostic testing occurring while participating in competitive athletics at said school or athletic organization, or otherwise medically related to such child.

I understand that I may revoke this Authorization by providing written notice to The Hughston Foundation, Inc., a Georgia nonprofit corporation. I also understand that if information has been released by relying upon this Authorization, that revocation will not be valid. I understand that injury treatment will not be conditioned upon signing this Authorization. I also understand that I am waiving my right to privacy with regard to the medical records and patient identifiable information by authorizing the release of my information.

I understand that the release of the medical information provided for herein is being carried out with my consent as the parent or legal guardian of such child, and accordingly, I assume full responsibility for any action taken in reliance upon this Authorization.

I UNDERSTAND THAT SUCH CHILD'S MEDICAL INFORMATION IS CONFIDENTIAL AND PROTECTED BY A PHYSICIAN-PATIENT PRIVILEGE AND THAT I, AS THE PARENT OR LEGAL GUARDIAN OF SUCH CHILD, AM WAIVING THE PHYSICIAN-PATIENT PRIVILEGE TO THE FULL EXTENT PROVIDED FOR HEREIN AND AS ALLOWED BY LAW.

_____ _____

Signature of Parent/Legal Guardian **Date**

_____

Print Name of Parent/Legal Guardian

_____ _____

Signature of Student Athlete **Date**

_____

Print Name of Student Athlete