STUDENT ATHLETE CONSENT FOR TREATMENT AND CARE

I, _____, parent or guardian of _____ recognize that as a result of athletic participation, medical treatment on an emergency or non-emergency basis may be necessary and further recognize that school personnel may be unable to contact me for my consent for such medical care. I do hereby authorize in advance to such emergency and non-emergency care, including hospital care, as may be deemed necessary under the then existing circumstances. The purpose of this release is to authorize the school to obtain, through a physician of its choice, any medical care that may become reasonably necessary for the student in the course of school athletic activities or school travel.

Additionally, I give my permission and consent for the evaluation and treatment of my child by the physicians at the CHRISTUS Health System, including CHRISTUS Saturday Sports Injury Clinic.

I hereby consent to and permit CHRISTUS Trinity Clinic Physicians/Staff (and/or their designee) to provide evaluation, medical treatment (including emergent or urgent treatment if necessary) to me/my child, including hospitalization and physician follow-up according to their medical judgment at the CHRISTUS Health System and/or its Saturday Morning Sports Injury Clinic.

I further authorize CHRISTUS Health System to obtain and release personal medical/insurance data about me for treatment payment or operations related to my injury, illness, physical examination(s) in accordance with the applicable state and federal privacy laws.

I am of sound mind and competent to sign this form.

I have read this form, understand it and agree to the terms and conditions.

_____ _____

Parent/Legal Guardian signature Date

_____ _____

Student/Athlete Signature Date