Parent / Legal Guardian Consent Form

STUDENT INFORMATION

Name: ____
Last First M.I.

School: ____

Sport(s): ____

Date of Birth: ____________________ Gender: M F Class of : ________

Address: ____

City: ____________________ Zip Code: ____________________

Home Phone:( ) ____________________ Student Cell:( ) ____________________

Student Email: ____

Medical Insurance: ☐ HMO ☐ PPO ☐ Medi-Cal ____________________
Name of insurance

Allergies: ____

Medical Conditions: ____

PARENT/LEGAL GUARDIAN:

Name: ____

Home Phone:( ) ____________________ Work Phone:( ) ____________________

Mobile Phone:( ) ____________________ Email: ____________________

EMERGENCY CONTACT:

Name: ____________________ Relationship: ____________________

Home Phone:( ) ____________________ Work Phone:( ) ____________________

Mobile Phone:( ) ____________________ Email: ____________________

Consent for Treatment:

I/we hereby authorize my consent to have the above athlete be treated now and in the future by Team HEAL personnel to conduct or administer any x-rays, examination, anesthetic, medical or surgical diagnosis, or treatment and hospital care that is deemed advisable by, and is to be rendered under, the general or special supervision of any physician licensed under the provisions of the Medical Practice Act on the medical staff of any accredited hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

This authorization shall remain in effect until revoked in writing.

Signature: ______________________________________ Date: ____________________

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