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, telemedicine, 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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