



# 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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