MONUMENT HEALTH

* E C O N O T H *

Patient
Last Name: _____

First Name: _____

Date of Birth: _____

Patient MRN #: _____

Athletic Training Consent and Release - Minor

General Information:

School Grade:_____

Sports: _____

Medical Information:

Patient Name:_____Date of Birth:_____

Medical Illnesses:_____

Allergies:_____

Medications:_____

(any medications that may need to be taken during competition requires a provider's note)

Previous neck/back injuries:_____

Previous Concussions:_____

Previous heat-related problems:_____

Previous surgeries:_____

Other information necessary to inform the medical staff:_____

Release of Liability

By undersigning below, I fully release, indemnify and hold harmless Monument Health , Inc., its affiliates and subsidiaries, its officers, directors, employees, volunteers, providers, agents, volunteer instructors and landlords (herein "Released Parties"), from any and all liability, claim and expense of any kind including, but not limited to, attorney's fees, related to any injury to my child including permanent injury or death that is caused in any manner, including those claims of negligence by the Released Parties or any other participant, by my participation in this athletic training program.

I intend for this Release to apply to my child's current and future participation in the above program, which shall remain in effect throughout his/her participation in the athletic training program. If I intend to revoke this release I agree to provide written notice to Monument Health, Inc. I understand this revocation shall not be effective until it is actually received by the CEO of Monument Health. I acknowledge I am fully aware of the nature of the athletic training program; what the athletic training program entails in terms of its impact upon the human body; the purpose of the athletic training program; the design of the athletic training program; the risks and the type of physical activity required for participation in the athletic training program. I understand it is my responsibility to have my child examined by a provider to determine my child's fitness for participation in this athletic training program. I agree my child is able to participate in this athletic training program and I choose for him/her to do so. I understand there may be exercise routines or other flexibility and stretching routines which might have an impact on my child's cardiovascular system, flexibility, balance, coordination, muscle toning and endurance. I acknowledge participants are advised to pace themselves during the course of the routines. I acknowledge the instructors and volunteers organizing this athletic training program are not responsible for monitoring my child's health conditions before, during, or after participation in the athletic training program. I acknowledge it is my responsibility to immediately seek medical care if needed for my child.

I accept full responsibility for my child's participation in this athletic training program and I waive any claim that the instructors or leaders for this athletic training program failed to properly supervise my child or train my child prior to or during my participation.

I acknowledge I have been advised to consult with my medical provider before participating in the athletic training program regarding any past or present injury, illness, cardiovascular problem, knee problems, or any other medical condition that may affect my child's participation and ability to participate in and to endure this or any exercise program .

MONUMENT HEALTH

* E C O N 0 T H *

Athletic Training Consent and Release - Minor

Patient Last Name: _____

First Name: _____

Date of Birth: _____

Patient MRN #: _____

Consent for Athletic Conditioning, Training and Health Care Procedures

I hereby give consent for my child to participate in the school's athletic conditioning and training program and to receive any necessary treatment, including first aid, diagnostic procedures and medical treatment that may be provided by treating providers, nurses and other healthcare providers. In the event that I cannot be reached in an emergency, I hereby give permission for my child to be transported to receive necessary medical treatment.

Is your son/daughter covered under a medical insurance policy? ☐ Yes ☐ No

If so, what company?_____

Sway Medical Consent

CONSENT FOR CONCUSSION TESTING and RELEASE OF INFORMATION

I give my permission for (name of child)_____ (child's DOB)_____ to have a baseline Sway Medical test performed. In addition, I give my permission for my child to have post-concussion Sway Medical administered at (name of school) _____ if needed. I understand that my child may need to be post-concussion tested more than once, depending upon the results of the test, as compared to my child's baseline test, which is on file at (name of school) _____
I understand there is no charge for the testing.

(Name of school) _____ may release the Sway Medical results to my child's primary care provider, neurologist, or other treating provider, as indicated below.

I understand general information about the test data may be provided to my child's guidance counselor and teachers, for the purposes of providing temporary academic modifications, if necessary.

PLEASE PRINT THE FOLLOWING INFORMATION:

Name of doctor: _____ Name of practice or group:_____

Phone Number:_____

Parent or guardian phone numbers (please indicate preferred contact number and time if necessary):

Home:_____ Work:_____ Cell:_____

Patient Name PRINTED: _____

Patient Signature: _____ Date: _____ Time: _____

Parent/Guardian Name PRINTED: _____

Parent/Guardian Signature:_____ Date: _____ Time: _____

Witness for Obtaining Telephone Consent Name PRINTED: _____

Witness Signature:_____ Date: _____ Time: _____