

**GREENVILLE HOSPITAL SYSTEM – CERTIFIED ATHLETIC TRAINING SERVICES
CONSENT AND AUTHORIZATION**

I, _____, parent/legal guardian of _____, a student at _____ (the "School"), authorize Greenville Hospital System ("GHS") staff to provide my child any healthcare services offered by GHS Certified Athletic Training Services and to make appropriate referrals for my child to receive any additional health services that my child's condition may indicate. To protect and improve the health of student athletes, GHS will provide an athletic trainer to provide on-site treatment and consultation to students at the School. These services will be overseen by a physician serving as Medical Director for Certified Athletic Training Services.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff at GHS Certified Athletic Training Services to arrange for such care, including appropriate transportation. I understand that GHS Certified Athletic Training Services staff will contact me as soon as possible in the event my child has an urgent or emergency condition.

I agree to complete all health history, family history, and other informational requests necessary for my child's participation in the Certified Athletic Training Services program. I understand that I may contact the trainer assigned to the School or the Medical Director for Certified Athletic Training Services to discuss my child's care or to discuss any questions I may have about the program. I consent to the release by GHS staff of information about my child's medical condition obtained through Certified Athletic Training Services to coaches and other employees or agents of the School.

I understand that I will not be charged for services rendered on-site by the trainer assigned to the School, but that I or my insurance carrier may be charged for services rendered by other healthcare providers. I consent for information in my child's medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize GHS to submit claims for services rendered to my child and assign to GHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by GHS Certified Athletic Training Services, I hereby release Greenville Hospital System, its trustees, officers, employees, and agents from and against any claim, liability, cause of action or other expense arising out of the services provided by GHS Certified Athletic Training Services.

I have read and understand the above information and consent to my child's participation in GHS Certified Athletic Training Services.

Name of Parent/Legal Guardian (please print)

Name of Student (please print)

Signature of Parent/Legal Guardian

Relationship to Student

Witness

Date

Emergency Contact Names

Telephone Numbers
Day _____ Night _____
Day _____ Night _____



GREENVILLE HOSPITAL SYSTEM

Name _____ DOB _____

SSN _____ Phone # _____

Grade _____ Sport(s) _____

Address _____

Mother _____ Work # _____

Home # _____ E-mail _____

Father _____ Work # _____

Home # _____ E-mail _____

Ins. Carrier _____

Claim/policy# _____

HMO/PPO (circle one)

Emergency contact _____

Phone #'s _____

Does your child have any of the following? (food allergies etc.; if so, list details as appropriate) Yes No

Asthma _____

Inhaler _____

Heart condition _____

Vision loss _____

Epilepsy _____

Diabetes _____

Kidney condition _____

Hearing loss _____

Allergies _____

Allergic to any medication _____

Severe headaches _____

Other

Previous injuries/surgeries (month/year)?

Date of last tetanus booster:

Is your child on any medication that is taken on a regular basis? (List)

Does your family have a primary care physician? (Name/phone #)

Does your family have an orthopaedic doctor? (Name/phone #)

My child may take any over-the-counter medication such as Tylenol®/Advil®. Yes No

Parent/Guardian Signature _____ Date _____