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**AUTHORIZATION FOR SPORTS MEDICINE SERVICES
AND CONSENT FOR TREATMENT**

I, the undersigned, am the parent/legal guardian of, _____, a minor and Student-Athlete for _____.

I, hereby give consent for a Certified Athletic Trainer and/or other Northeast Rehabilitation Health Network clinical staff, who is contracted by the school to provide sports medicine services for the above minor. This sports medicine clinician is from Northeast Rehabilitation Health Network. Sports medicine services include, but are not limited to: administrating first aide for athletic injuries, providing initial treatment and management of acute injuries, and assessing athletic injuries at the request of the athlete, the athlete's coach, or the athlete's parent/guardian. The Athletic Trainer and/or sports medicine clinical staff will perform only those procedures that are within their training, credential limitations and scope of professional practice to prevent, care for and rehabilitate athletic injuries. I understand that a written report of any athletic injury assessment will be confidentially maintained in the files of the training room or school nurse's office.

I hereby authorize the Athletic Trainer and/or other Northeast Rehabilitation Health Network clinical staff to share information about the injury assessments and post injury status. This will be done as needed, with the coaching staff, the school's Athletic Director and if necessary; the school nurse, the athlete's PCP, treating physician and/or any other treating healthcare provider.

I understand that there is no charge to me for the above listed Athletic Training services. If the athlete is in need of further treatment by a physician, or of rehabilitation services for the injury, he or she may see the physician of his/her choice. Injured athletes that have seen a physician must submit written clearance from that physician prior to being permitted to resume activity.

Parent/Guardian Signature _____
Parent/Guardian Name (print) _____
Relationship to student athlete _____
Home Address _____
Home Phone _____ Work phone _____

Student Athlete Name _____
Sport _____ Grade _____
Allergies _____
Current Medications (ie asthma inhalers, epi-pen) _____
Physical impairments _____
Other pertinent medical history (diabetes, seizures, heart condition, etc) _____
Family Physician _____ Physician Phone _____

Revised 05/10