OPTIMUM PERFORMANCE SPORTS

MEDICAL TREATMENT CONSENT

I, the parent / legal guardian of ______________________________________ give permission to the attending sports medicine personnel (i.e., certified athletic trainer, team physician, physical therapist) to provide on-site evaluation and
treatment.

I authorize the attending FWO/OPS sports medicine personnel to discuss the athlete's minimum necessary medical information
with appropriate coaching and athletic administrative personnel.

Parent / Guardian Signature ____
Phone Number _______________________________________ Date ___________________________
Athlete's Birth Date ____________________ Hospital Preference __________________________________
Insurance Name ______________________________ ID No. __________________________________
Group No. _____________________________ Benefits Phone No. _______________________________
Subscriber's Name ____________________________________ Date of Birth ______________________
Employer ____

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