



**CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE OF ATHLETIC HEALTH INFORMATION**

<b>ATHLETE NAME:</b> _____		
Last	First	Middle
<b>SCHOOL:</b> _____	<b>SPORT(S):</b> _____	
<b>PHONE NUMBER:</b> _____	<b>DATE OF BIRTH</b> _____	

I am aware that the designated team physician for Cuyahoga Falls High School Athletics will be provided by Summa Akron City and St. Thomas Hospitals or its affiliates. By providing my signature below, I consent to medical care and treatment provided by the team physician and athletic trainer to my child. I understand that this care may include triage, evaluation, examination, special tests, and medical treatment of injuries sustained during participation in OHSAA athletic events. I understand that as a result of the medical evaluation, my child may be transported to a hospital emergency department for further treatment.

I am also aware that if my child sustains an injury and is participating in an interscholastic sport, it is imperative that the team physician be able to communicate with the athletic trainer, coaches, staff, medical personnel, administrators, the child’s parents and other physicians. **I hereby authorize the team physician providing the coverage for my child’s school, employed by Summa Akron City and St. Thomas Hospitals or its affiliated Hospitals to communicate with the aforementioned personnel and acknowledge and authorize such personnel to communicate with the team physician.**

**PURPOSE OF DISCLOSURE:**

- a. Injury / Illness information
- b. Playing and participation status
- c. Return to play status

**FOR THE FOLLOWING DATES OF SERVICE/COVERAGE:** July 20, 2011 - June 15, 2012

\_\_\_\_\_  
Signature of Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Athlete’s Parent/Guardian

\_\_\_\_\_  
Date