Fenwick ATHLETICO PHYSICAL THERAPY Fenwick

CONSENT TO TREAT AND EMERGENCY CONTACT INFORMATION FORM

SPORT(S): _____

GRADE: _____

LAST NAME: _____ **FIRST NAME:** _____

ADDRESS: _____

CITY: _____ **ZIP CODE:** _____

DATE OF BIRTH: _____

TELEPHONE: **HOME:** _____ **CELL:** _____

E-MAIL: _____

EMERGENCY CONTACT: _____ **RELATION:** _____

EMERGENCY CONTACT NUMBER: _____

PRIMARY CARE PHYSICIAN (IF APPLICABLE): _____

ORTHOPEDIC PHYSICIAN (IF APPLICABLE): _____

INSURANCE NAME: _____ **EXPIRATION DATE:** _____

PLEASE LIST ANY SIGNIFICANT INJURIES, ALLERGIES, AND DATES OF SURGERY:

_____

_____

_____

I understand and recognize that Athletico services may include first aid treatment and education to assess a current injury. I acknowledge that my son/daughter may be evaluated by a physical therapist, occupational therapist, physical therapist assistant, occupational therapy assistant or athletic trainer and not a physician. I understand that these services are not a substitute for medical examination, diagnosis, or a physician's care. I understand that my son/daughter may receive a referral to a health care provider for further diagnosis and treatment. By allowing Athletico to provide me with these services, I hereby waive, release, and discharge any and all claims against Athletico and its employees for legal liability for performing these services.

_____ _____

PLAYER/PARENT SIGNATURE **DATE**