Consent for Treatment

I hereby authorize the Certified Athletic Trainers and Sports medicine staff acting on behalf of E.C. Glass High School to evaluate and treat any injury/illness that occurs as a result of my participation in athletics. This includes any and all reasonable and necessary preventative care, taping, treatment, modalities and rehabilitation for these injuries/illnesses. This also includes the use of electrolyte tablets (Medi-Lyte, FosFree, Heat Guard, GatorLytes), electrolyte drinks (Powerade/Gatorade), and food/snacks as necessary.

When under medical care I may not return to participation until I have been given permission by the overseeing Physician or Certified Athletic Trainer, if deemed necessary. This may occur during or at the conclusion of medical treatment. *The overseeing physicians have the FINAL authority regarding participation status following injury/illness.*

I understand and agree that if I experience an injury/illness or change in my health status it is my responsibility to inform the Certified Athletic Trainer and my Head Coach. I also agree to adhere to the established injury management guidelines including rehabilitation and reassessment before I am released to return to full participation.

I understand that if my student-athlete participates in a catastrophic, collision, or contact sport, they will have a baseline ImPACT neurocognitive test given to them. This is used as a part of the concussion management procedures, Repeat testing is completed following a concussion injury and the results are compared to the baseline assessments. This testing aids the physician and Certified Athletic Trainer in the Return to Play process.

This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

_____	_____	_____
Student-Athlete-Print Name	**Student-Athlete-Signature**	**Date**
_____	_____	_____
Parent/Guardian-Print Name	**Parent/Guardian-Signature**	**Date**

Authorization to Disclose Private Health Information

I grant permission to E.C. Glass High School's Certified Athletic Trainers to disclose my Personal Health Information (written and/or verbal), when requested to do so, for the purposes of health care treatment, or for any other purpose which is permitted or required by law.

Personal Health Information includes, but is not limited to: information involving the nature and treatment of an injury/illness, medical history, insurance coverage and copies of all hospital and medical records. This information will be released ONLY for the purposes of further treatment (referrals to specialists or other health care providers), disclosure of participation status to your team's coaches for your health and safety.

In order to maintain continuity of care and provide participation status updates to athletic department personnel, I hereby authorize the Certified Athletic Trainers to disclose injuries/illness contained in my student-athlete medical file, including medical conditions(s), treatment and rehabilitation status, and participation restrictions to the following entities:

a) Physicians: OrthoVirginia
b) E.C. Glass High School Athletic Administration / Coaches
c) Parents/Guardians: (names)_____

This authorization expires one (1) year from the date signed. It may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

_____	_____	_____
Student-Athlete-Printed Name	**Student-Athlete-Signature**	**Date**
_____	_____	_____
Parent/Guardian-Printed Name	**Parent/Guardian-Signature**	**Date**