

STEELE MEMORIAL MEDICAL CENTER

P.O. BOX 700 ~ SALMON, ID 83467 ~ (208)756-5600 ~ FAX (208) 756-4169

Department of Sports Medicine Treatment Consent Form

Name _____ Date of Birth _____ Sport(s) _____

Consent:

By signing below, I hereby give my consent for physical assessments, IMPACT evaluations, treatment of injuries, or emergency medical treatments by Steele Memorial Medical Center's Licensed Athletic Trainer (LAT), specialized physician, and/or other emergency personnel as indicated.

Signature of student-athlete

Date

Signature of parent/guardian

Date

Person to contact in case of emergency:

Name _____ Relationship to student _____

Phone _____ Alternate Phone _____