



GRANT REGIONAL COMMUNITY CLINIC

Sports Physical at School Parent Consent Form

I, _____, parent or legal guardian of
(parent/guardian name)

_____, born ____/____/____, do hereby
(student athlete name) (student's date of birth)

Authorize Grant Regional Health Center to perform a sports/school physical on

____/____/____ at _____.
(date of sports/physical exam) (student's school)

I understand this is a pre-season sports physical screening exam. It is not a comprehensive exam, and it is not intended to provide treatment nor to create a provider/patient relationship. I understand that athletic participation comes with the risk of injury. This screening exam cannot detect all problems or prevent injury from athletic participation. I understand that if follow-up evaluation is recommended, it is my responsibility to seek care from an appropriate provider.

I certify I am the parent/legal guardian for this athlete/minor. I understand the information above.

Signature of Parent/Guardian

____/____/____
Date

(____) _____ - _____
Parent/Guardian Day Contact Number

(____) _____ - _____
Parent/Guardian Cell Number

GRANT REGIONAL HEALTH CENTER

Patient Name: _____

Date of Birth: _____

Patient's Address: _____

Patient's SS# _____ Phone #: _____

Parent/Guardian Name: _____

Parent/Guardian Date of Birth: _____

Parent/Guardian Address: _____

Parent/Guardian SS#: _____

Parent/Guardian's Employment: _____
