AUTHORIZATION FOR MEDICAL EXAMINATION AND TREATMENT

Student Information:

Name: ____
Address: ______________________________________
City: ____
Date of Birth: __________________________________

My child, identified above, participates in the athletic program at:

____
(Name of School)

During my child's participation in the athletic programs of the school listed above, I understand that he/she will be under the care of certified athletic trainers who are provided by Houston Healthcare. I do hereby consent to any examination, medical care and/or treatment deemed medically necessary or appropriate by the team physician, athletic trainer or coach.

This consent to treatment is granted pursuant to the provisions of the Georgia Medical Consent Law, Official Code of Georgia Annotated, Title 31, Chapter 9 and shall be construed in accordance with that statute.

This authorization covers the school year: ______________

________________________________ ______________
Signature of Parent/Guardian Date

____
Print Name