**Cartersville High School**

**Sports Medicine**

**Consent for Treatment**

**2024-2025**

I hereby authorize the Cartersville High School certified athletic trainer, Phillip Hardy, PT Solutions certified athletic trainer, Josh Tucker, and sports medicine staff acting on behalf of Cartersville High School to evaluate and treat any injury/illness that occurs as a result of my participation in athletics. This includes any reasonable and necessary preventative care, treatment, and rehabilitation for these injuries/illnesses. I understand that I must refrain from practice while injured/ill, whether or not receiving medical care. When under medical care, I may not return to participation until I have been given permission by the Physician, their delegate, or the Certified Athletic Trainer if deemed necessary. This may occur during or after 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 my Head Coach and the Certified Athletic Trainers. I also agree to adhere to the established injury management guidelines, including rehabilitation and reassessment, before I am released to return to full participation. This authorization expires one (1) year from the date signed and may be revoked at any time provided written documentation of the revocation is on file in the athletic training room.

**Print Student Name Student Signature Date**

**Parent/Guardian Signature (if student-athlete is under 18 years of age)**

Authorization to Disclose Private Health Information

I grant High School’s Certified Athletic Trainers permission to disclose my Personal Health Information (written and verbal) when requested, for health care treatment, or for any other purpose 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 further treatment (referrals to specialists or other health care providers) and disclosure of participation status to your team’s coaches for your health and safety. To maintain continuity of care and provide participation status updates to athletic department personnel, I hereby authorize the Certified Athletic Trainer 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) Physician: Dr. Andy Riddle, Georgia Bone and Joint

b) Cartersville High School Athletic Administration

**c) Parents/Guardians: (names)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Print Student Name Student Signature Date**

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