Spectrum Health Medical Group--Sports Medicine Consent Form

I understand that _____ School has contracted with Spectrum Health Medical Group for the provision of sports medicine services, including services furnished by Spectrum Health employed medical providers and athletic trainers to student-athletes. The sports medicine services furnished by medical providers and athletic trainers include, but are not limited to, the following services:

- Evaluation of orthopedic injuries and general medical concerns
- Treatment of orthopedic injuries, including, but not limited to:
  - Injury/illness education and care recommendations
  - Modalities: Ice, Heat, electrical stimulation and ultrasound
  - Exercise prescription/Home exercise programs
  - Manual therapy techniques
- Injury prevention and strength and conditioning programs
- Event coverage, injury management, and assistance with management of participation status

Photographic, video and telemedicine technology may be used for purposes of identification, diagnosis and/or documentation of an injury or condition. This allows athletic trainers to send electronic images to off-site medical providers and athletic trainers, for consultation purposes. Spectrum Health requires that an adult (e.g. parent, coach, or teacher) must be present with the student-athlete whenever photographs and/or video images are taken. Use of any photographs, video, or telemedicine technology must follow Spectrum Health Standards.

I hereby give my permission and consent for Spectrum Health-employed medical providers and athletic trainers:

- To furnish sports medicine services to the student-athlete named below.
- To communicate with coaches regarding matters related to the condition and treatment of the student-athlete named below.
- When clinically appropriate, to use photographic, video and telemedicine technology while providing sports medicine services to the student-athlete named below.

_____ _____ Date:_____

Parent/Guardian Signature Parent/Guardian Printed Name

Emergency Contact Information

Student/Athlete Name:_____**Team:**_____ **Grade:**_____

Date of Birth:_____ **Age:**_____ **Cell Phone:**_____

Home Address:_____

Street **City** **State** **Zip**

Parent/Guardian:_____ **Relationship to Student:**_____

Home Phone:_____ **Cell Phone:**_____

PARENT EMAIL ADDRESS: _____

By providing your email address you are agreeing to receive emails from the athletic trainer or our third party documentation and engagement tool, Healthy Roster. Your information will not be shared outside of the athletic trainer and will be used to communicate about athlete injuries or information about our program.

PLEASE RETURN THIS FORM TO YOUR ATHLETIC TRAINER