



Consent to Treatment and Release of Medical Information

Name: _____

Date: _____ Sport(s): _____ DOB: _____

I give authorization to the Gwinnett Hospital System (GHS) athletic training staff and student athletic trainers working with the GHS athletic training staff, to evaluate and treat any injuries or illnesses that may occur during his/her athletic participation at DULUTH HIGH SCHOOL.

This includes immediate first aid to my child, treatment, physical exam, and diagnostic procedures. No guarantees have been made that the evaluation, treatment, or rehabilitation services that my child receives will cure or fully return him/her to athletic participation.

I authorize necessary medical treatment and admission to any medical facility designated by the GHS athletic training staff or team physician.

I understand that I have the right to make decisions concerning my child's health care, including the right to refuse medical treatment and surgical procedures. However, I also understand that the final decision as to whether my child may participate in athletic activities at DULUTH HIGH SCHOOL rests solely with the GHS athletic training staff and team physician.

Parent/Guardian Signature _____ Date _____

To Athletic Trainers, Physicians, Hospitals, Clinics, and all Other Agencies:

If needed, You are hereby authorized and requested to give the GHS athletic training department a complete copy of all your records pertaining to my child's medical treatment including, but is not limited to, all physicals, athletic trainer's records, and any diagnosis, treatment, history and prognosis of any and all injuries.

Parent/Guardian Signature _____ Date _____

These authorizations are effective until such time that the signee submits a written and dated revocation of this document.

Gwinnett Medical Center

1000 Medical Center Boulevard | Lawrenceville, GA 30045 | 678-312-4321 | gwinnetmedicalcenter.org