Authorization for Sports Medicine Services and Consent for Treatment for the 2026-2027 School Year

I, the undersigned, am the parent/legal guardian of, _____ (**student's name**), a minor and student-athlete at _____ (**school name/organization**) who plans to participate in _____ (**sports)**.

I understand that Horizon Health (HH) is contracted by the school/organization to provide sports medicine services. Additionally, athletes are able to make an appointment to be seen by an Athletic Trainer in the clinic for an injury check.

- I hereby give consent for the Sports Medicine Staff to provide appropriate medical services for the above minor, within their scope of practice. Sports medicine services may be provided by but are not limited to an Orthopedic Doctor, Athletic Trainer, Nurse Practitioner, Physical Therapist or Physical Therapist Assistant.
- I hereby authorize the Sports Medicine Staff, who provides services to this student-athlete, to disclose information about the athlete's injury assessments and post-injury status, in compliance with HIPAA.
- I understand such disclosures will be made as needed to the involved coaching staff, Athletic Director, school nurse, and any additional healthcare provider treating the athlete. I understand and agree that requests to limit information sharing must be submitted in writing.
- If the athlete is in need of further medical treatment, he/she may see the physician or provider of his/her choice.

★ Injured athletes who have been referred and/or evaluated by a provider, must provide written clearance/orders outlining return to activity and/or treatment recommendations to the athletic trainer, for athletic trainer to resume treatment/care of evaluated injury.

This authorization shall remain effective until the end of the 2026-2027 school year.

Parent/Guardian name _____ Signature _____

Medical History

Student Athlete's Full Name _____ Gender ____ Grade ____ Date of Birth _____

Allergies (including severity and known reaction): _____

_____

Related Medical History (including but not limited to orthopedic injuries, previous surgeries, ongoing health conditions, etc.) _____

_____

Current Medications _____

Emergency Contact Information

For your athlete's benefit, please include primary contact and additional contact, if the primary contact is unavailable.

Do both parties need to be called separately if/when a parent/guardian needs to be contacted: **Y / N**

Parent/Guardian Name _____ Relationship to student athlete _____

Cell Phone _____ Email _____

Parent /Guardian Name _____ Relationship to student athlete _____

Cell Phone _____ Email _____

Updated May 2026