OPS
OPTIMUM PERFORMANCE SPORTS

MEDICAL TREATMENT CONSENT

I, the parent / legal guardian of _____ give permission to the attending sports medicine personnel (i.e., certified athletic trainer, team physician, physical therapist) to provide on-site evaluation and
treatment.

I authorize the attending FWO sports medicine personnel to discuss the athlete's minimum necessary medical information
with appropriate coaching and athletic administrative personnel.

Parent / Guardian Signature _____
Phone Number _____ Date _____
Athlete's Birth Date _____ Hospital Preference _____
Insurance Name _____ ID No. _____
Group No. _____ Benefits Phone No. _____
Subscriber's Name _____ Date of Birth _____
Employer _____

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