

**CONSENT TO TREAT AND AUTHORIZATION FOR RELEASE  
OF ATHLETIC HEALTH INFORMATION**

ATHLETE NAME: \_\_\_\_\_  
Last First Middle

PHONE NUMBER: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

Eastern Pulaski Community School Corporation SPORT(S): \_\_\_\_\_

I am aware that the Athletic Training services and care for Eastern Pulaski Community School Corporation will be provided by Pulaski Memorial Hospital (PMH). By providing my signature below, I **CONSENT** to medical care and treatment provided by the athletic trainer(s) and other PMH Medical personnel. I understand that this care may include triage, evaluation, examination, special tests, cognitive testing (ImPACT baseline and post-concussion testing) and limited medical treatment of injuries sustained during participation in IHSAA athletic events and practice. I understand that as a result of the medical evaluation, the student-athlete may be transported to a hospital emergency department for further treatment. I hereby **RELEASE AND HOLD HARMLESS**, Pulaski Memorial Hospital, its officers, directors, employees, and Medical Staff members from any and all **LIABILITY, CLAIMS OR DAMAGES** connected with any care which is deemed reasonably necessary to the health and well-being of the student-athlete.

I am also aware that if the student-athlete sustains an injury and is participating in an interscholastic sport, it is imperative that the athletic trainer and other PMH medical personnel be able to communicate with coaches, staff, medical personnel, administrators, and primary care/specialty providers. I hereby **AUTHORIZE** the athletic trainer(s) and other PMH medical personnel providing the coverage for the student-athlete's school, employed by Pulaski Memorial Hospital to **DISCLOSE** athletic health information to the aforementioned personnel.

**PURPOSE OF DISLOSURE:**

- a. Injury / Illness information
- b. Playing and participation status
- c. Return to play status

\_\_\_\_\_  
Signature of Athlete

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Athlete's Parent/Guardian

\_\_\_\_\_  
Date

**ATHLETIC TRAINING SERVICES**



Pulaski Memorial Hospital  
Winamac, IN 46996  
(574) 946-2157  
Form MM-1132 Rev. 5/2018



Sponsored by: Pulaski Memorial Hospital