

614-293-3600 Phone

https://wexnermedical.osu.edu/sports-medicine

CONSENT TO TREAT – Minor

I, ______, give consent for the staff of The Ohio State University Wexner Medical Center's Sports Medicine program to provide my child, ______, medical treatment, first aid, emergency medical care and or rehabilitative treatment during the Ohio State University Marching and Athletic Bands activity, hereafter referred as "Band Activity".

I understand that as a service to the sponsors and the participants of the Band Activity, The Ohio State University Wexner Medical Center's Sports Medicine Department has agreed to provide preventative medical treatment, first aid, emergency medical care and rehabilitative treatment. While the Sports Medicine program employs athletic health care providers such as physicians, nurse practitioners, nurses, physical therapists and athletic trainers who are qualified to evaluate, treat, and rehabilitate certain injuries that participants may incur while participating in the Band Activity, the staff are not assuming the role of my child's personal health care provider. I understand that I need to provide them with any and all of my personal heath information that might impact the services they provide to my child.

Permission is hereby granted to the Sports Medicine staff, when necessary or advisable for my child's care and treatment, to hospitalize, schedule appointments, and communicate with other physicians, medical care providers, athletic trainers counselors and all directing band staff regarding my child's medical history and or treatment. Permission is granted to discuss my child's injuries with necessary third parties, including but not limited to, the directing band staff as relevant to my child's participation in this Band Activity. This authorization is valid for one year, unless revoked by my written notice, provided said notice is received prior to release of the above-designated information. Information released by this authorization may no longer be protected by federal privacy rules, such as HIPAA, and may be subject to re-disclosure.

In consideration for the medical services provided to my child, I, acting for my child, myself, my executors, administrator and assigns, do hereby release and forever discharge The Ohio State University, its Board of Trustees, its respective entities, administrators, faculty members, employees, and agents, including OSU Physicians Inc. and its physicians, from any and all claims that I might have with regard to damages, demands, or any actions whatsoever, including those based on negligence, in any manner arising out my child's participation in this Band Activity.

I have read this entire Agreement to Release and Indemnify the University. I fully understand it, and I agree to be legally bound by it.

Parent/Legal Guardian Name (Printed)	Parent/Legal Guardian Signature	Date
R <u>EMERGENCY INFO AND CONTACT</u>	Relationship to Participant	
Participant Name	Date of Birth	Age
List all Known Allergies/Chronic Illness/ Medic	ations or Health Concerns:	
In case of emergency, Contact Name	Relationship	
Cell Phone	Home Phone	