Athlete's Name: _____ DOB_____

Consent for Treatment. I, the athlete, or my representative, wishes to participate in the Reid Sport Medicine High School Athletic Physicals program. I understand that some of the individuals that are providing all or a portion of the examination may not be employees or agents of Reid Hospital and Health Care Services (Reid Hospital), Reid Rehabilitation Services (Reid Rehab) or Reid Physician Associates (RPA). I authorize the participating allied health personnel and physician, regardless of their employment status with Reid Hospital, Reid Rehab or RPA to render a pre-participation athletic physical examination on me. I understand that Reid Hospital, Reid Rehab and RPA are not responsible for those individuals who are not their employee. I understand that the practice of medicine is not an exact science and acknowledge that no guarantee has been made to me as to the result of this examination. I understand that it is my right to consent or to refuse consent for this examination I understand that the information and forms for this examination will be forwarded to the athlete's school system and maintained in part by Reid Hospital. I understand that Reid Hospital, Reid Rehab and RPA will not be responsible for any valuables brought to any Reid Hospital, Reid Rehab or RPA facility by me.

I have read or had the opportunity to read the Consent for Treatment or it has been fully explained to me, and I am satisfied that I understand its content and significance. My consent is given freely, voluntarily and without reservation.

_____ _____

Patient or Responsible Person's signature Date/Time

(if 18 years or older and appropriate)

Reid Hospital& Health Care Services
Richmond, IN 47374 (765) 983-3000
General Consent for Pre-participation
Athletic Physical Examination