LINDSEY WILSON COLLEGE SPORTS MEDICINE

CONSENT TO TREAT/MEDICAL RELEASE FORM

I,____, age,________, while participating in the intercollegiate athletic program at Lindsey Wilson College, hereby consent to be treated by the Lindsey Wilson College Sports Medicine Staff, Team Physician(s), School Nurse, or any other medical doctor recommended by the Team Physician or Lindsey Wilson Sports Medicine Staff.

I expressly authorize the School Nurse and such hospital and /or medical doctor or medical facility, which might render medical treatment to me during this period, to release my medical condition and activity capabilities to Lindsey Wilson Sports Medicine Staff.

I also give Lindsey Wilson College Sports Medicine permission to provide other medical facilities with medical and insurance information that would expedite my care should I need emergency or other patient services.

Date: ____

Athlete Signature: ____

Parent/Guardian Signature (if athlete is under 18 years of age): _______________

LWCSM
CT/MR
Rev. 3/2010