Vernon Memorial Healthcare
So much care, so close.

Athletic Trainer Consent Form

Print Name: _____ DOB: ____/____/____ School: _____

To be read and signed by the student-athlete ("student") and the parent / legal representative if the student is under 18 years old.

1. CONSENT FOR ROUTINE OR EMERGENCY CARE: I hereby authorize a Licensed Athletic Trainer ("LAT") employed by Vernon Memorial Healthcare (VMH) to evaluate and treat any injuries incurred by the student. Potential injuries could include but are not limited to, sprains, strains, fractures, abrasions, dislocations, concussions, and other athletic injuries. I understand that signing this permission form does not limit or modify my right to take the student to see a family physician or specialist and that I may do so at any time. By giving this permission, I understand that the LAT may be in direct contact with the student, that such contact may be prolonged in duration, occurring in proximity, and may require physical contact between the LAT and the student (i.e., hands-on, care-related activities). I understand the LAT may be involved in establishing a safe return plan for the student post-injury. I also give my permission to the LAT to inform school officials and medical provider of the student's injury and changes in injury status as they occur.

   During an emergency, the LAT may do what is needed to support the safety and health of the student. These actions may include treatment, activation of the Emergency Medical System (EMS), and contact with the parent/student's legal representative. The LAT will consult the parent/student's legal representative about any additional treatment the student may need.

2. ADDITIONAL INFORMATION
   a. I understand that the student may participate in baseline and post-injury concussion neurocognitive testing.
   b. I understand that the student must refrain from practice while injured and/or ill, whether receiving medical care or not. When under medical care, the student may not return to participation until given permission by a physician, physician's delegate, or licensed athletic trainer. This may occur during or at the conclusion of medical treatment. The overseeing health care provider has the final authority regarding participation status following injury/illness.
   c. I understand and agree that, as a student, if I experience an injury, illness, or change in health status it is my responsibility to inform the head coach and the licensed athletic trainer. Students must adhere to the established injury management guidelines, including rehabilitation and reassessment before being released to return to full participation.
   d. I understand that at athletic trainer discretion, the student may be referred to additional healthcare providers for diagnosis and treatment of any injury and/or illness. It the responsibility of the parent/legal representatives to arrange for care.
   e. I hereby authorize the VMH LAT to view and document in the electronic health record which includes protected health information directly related to the evaluation and treatment of a known or suspected injury sustained during athletic participation or for an injury and or illness that interferes with the ability to participate.
   f. This authorization is effective the entire student's high school career and only needs to be signed once. I understand that I may withdraw this consent at any time by submitting my request in writing to the Manager of Health Information, 507 South Main Street, Viroqua, WI 54665.

The undersigned certifies that the student and parent/legal representative has read this form, understands its content and significance, and is competent and authorized to execute it on the student's behalf.

_____ _____
Student Signature Date

_____ _____
Parent/Legal Representative Signature (if student athlete is under 18 years of age) Date