St. Charles Hospital
Catholic Health Services
At the heart of health

Centereach Office
2100 Middle Country Rd
(631)580-2526

CONSENT FOR PARTICIPATION

Sports Medicine Recovery and Injury Prevention Program

Patient Name:_____ Date of Birth: _____Age:_____

Parent/Guardian Name:_____ Phone Number:_____

1. I hereby authorize my child _____ (child's name) to participate in the Sports Medicine Recovery and Injury Prevention Sessions at St. Charles Hospital and to have any injury screenings performed by the therapy staff as needed while participating on the following school sport team:

   Season: (check one) ☐ Fall ☐ Winter ☐ Spring Year:_____
   Sport:_____ Level: ☐ JV ☐ Varsity School:_____

   (Separate consent required for each season and sport)

2. I hereby authorize the therapy staff to provide injury screenings and injury prevention/wellness education and interventions for my child_____ (child's name).
3. I understand that participation is voluntary and does not obligate me or my child to seek treatment if warranted by St. Charles Hospital providers.
4. I understand that recovery and injury preventions interventions may include application of hot packs, cold packs, ice baths, stretching and soft tissue massage as well as education and instruction in home activities.
5. I understand that during injury screenings my child may be asked to participate in activities to assess strength range of motion, aerobic capacity and other physical functions. This screen and all its procedures associated with it are **voluntary** and can be stopped at any time.
6. I have been given the opportunity to ask questions of the therapy staff concerning my child's present physical condition and I feel I have sufficient information to give informed consent for my child.
7. I certify that my child and I have been advised of our rights and that my son/daughter has no other medical conditions that contraindicate/limit my child from participating in this program or any injury screen.
8. In case of medical emergency, I understand that every reasonable attempt will be made to contact me should I not be present. However, in the event that I or my named contact cannot be reached, I give permission for the staff of St. Charles Hospital to secure emergency medical treatment for my child.

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE CONSENT

_____ _____
Parent/Guardian Signature Date

_____
Parent /Guardian Name PRINT

_____ _____
Signature of Witness Date