AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION CONSENT FOR TREATMENT: U18 Sports Medicine Program

Minor's Name:		Date of Birth:
Please list all the Minor's Medication and Medical Con	ditions:	
I, hereby authorize physicians, nurses, athletic trained Memorial Healthcare System ("MHS") to conduct rour deemed necessary in order for the above minor child occurs to Child while participating in school athletics, Child appropriate and necessary care at that time. If with on school grounds, I further authorize and give put to a medical facility. I understand that efforts will be emergency.	tine medical, medical scr ("Child") to participate in I further authorize and g medical necessity exists permission to Providers to	eenings, diagnostic or any other procedure school athletics. In the event that an injury ve permission to Providers to render to my beyond that which can be reasonably dealt arrange for professional medical transport
I understand the MHS has both employed and indep these individuals are not always employees or agents physician groups to provide services to patients and the agents or employees of MHS. I understand that Mindependent contractors or these individuals that are have been made to me regarding the results of any eagent, or independent contractor.	s of MHS. I also understa hat they may be independ MHS is not legally resp not employees or agents	nd that MHS contracts with physicians and dent contractors and are not necessarily the consible for the acts and omissions of its of MHS. I acknowledge that no guarantees
I hereby authorize physicians, nurses, athletic train contractors of MHS to examine and evaluate Child at County or its employees, school officials, coaches, teadetermining Child's ability to participate in school examinations, medical screenings, past or present he have a bearing on Child's ability to participate in school disclosed pursuant to this authorization may be subject protected by Federal confidentially laws or MHS.	nd to release the health is achers or agents, for the I athletics. The health salth information or information athletics. I also under the collections are the collections.	nformation to the School Board of Broward ourpose of engaging in school athletics and information consists of history, physical, ation pertaining to injury or illness that may erstand that the health information used or
I understand that authorizing the disclosure of this he condition treatment, payment, enrollment or eligibility may revoke this authorization at any time by notifying revoke this authorization, it will not have any effect on be effective until revoked or until the Child reaches e system.	for benefits on whether g, in writing, the MHS rep actions taken by MHS p	I sign this authorization. I understand that I resentative at Child's school. In the event I rior to the revocation. This authorization will
PARENT(S) / GUARDIAN(S)		
Ву:		
Printed Name:	Date Signed	Relationship to Child
By:		
Printed Name:	Date Signed	Relationship to Child
Memorial Healthcare System Authorization For Release Of Medical Information Consent For Treatment: U18 Sports Medicine Program	PATIENT/LABEL	