CONSENT FOR TREATMENT

I hereby authorize licensed Stewart Memorial Community Hospital sports injury staff acting on behalf of South Central Calhoun School to evaluate and treat any injury that occurs as a result of my participation in athletics at South Central Calhoun School. This includes all reasonable and necessary preventive care, treatment and rehabilitation for these injuries.

________________________________ ____________________________

Printed Name Date

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Signature of Student Athlete (or Parent/Guardian for minor, or where required)