Parental Consent for Athletic Training Services

Blessing Health System and _____ (School Name/District)

Student Name (Print): _____ Date of Birth: _____
Sport(s): _____

Purpose
Our school partners with Blessing Health System to provide athletic training services to student-athletes. These services are provided by licensed athletic trainers, working under the direction of a supervising physician and in collaboration with school coaches and staff.

Scope of Services
By signing below, I authorize the Blessing Health System athletic trainer(s) to:

- Evaluate, treat, and manage injuries/illnesses that occur during school-sponsored athletic activities (such as practices, games, and conditioning sessions). The head coach and licensed athletic trainer are to be informed of any injury/illness or change in health status.
- Provide first aid, taping, bracing, and other reasonable therapeutic interventions, within their professional scope.
- Communicate with coaches, school staff, and team physicians regarding my child's injury status and participation clearance. I/We understand my child must refrain from practice while injured/ill until given permission by a physician, licensed athletic trainer, or their delegate.
- Refer my child to a physician or other healthcare provider for additional evaluation or treatment when necessary. I/We are responsible for making the arrangements for follow-up care.
- Activate emergency medical services, which may include transfer to a hospital or other facility, and to provide emergency care within the athletic trainer's capabilities.

Health Information and Communication
I/We understand that limited health information related to my child's care may be shared among Blessing Health System athletic trainers and staff, supervising physicians, school personnel, and other healthcare providers to coordinate care and student health safety, in compliance with HIPAA and FERPA regulations.

Liability and Treatment Disclaimer

- I/We understand that the athletic training services provided by Blessing Health System are intended for the immediate care, management, and prevention of athletic injuries related to school-sponsored activities.
- I/We acknowledge that these services do not replace regular medical care or evaluation by my child's personal healthcare provider.
- I/We release, indemnify and hold harmless all entities within Blessing Health System, its employees, agents, and affiliates, as well as School referenced above, from any liability arising from the good-faith provision of athletic training services, except in cases of gross negligence or willful misconduct.

Consent
I/We have read or had this form read to me and understand the information above. I/We are authorized to consent and sign on said student's behalf. I/We give permission for my child to receive athletic training services as described herein for this full academic school year. I/We understand that I/We may revoke this consent in writing at any time.

Date	Time	Parent/Guardian (PRINT)	Parent/Guardian Signature

Optional:

Date	Time	2nd Parent/Guardian (PRINT)	2nd Parent/Guardian Signature

Emergency Contact Number(s): _____

BLESSING HOSPITAL

Official copy located at https://blessing-forms.policystat.com/