Print Form

TEAM PHYSICAL THERAPY

SPORTS INJURY
CONSENT TO TREAT A MINOR

Patient Name: _____ Date: _____
Last First Middle Initial

School Name: _____ Phone No: _____

Sport: _____ Athletic Trainer/Coach: _____

Date of Injury: _____ Nature of Injury: _____

Home Address: _____
Street City State Zip

Home Phone No.: _____ Date of Birth: _____ Age: _____

Social Security No.: _____ Sex: ☐ Female ☐ Male

Financially Responsible Party:

Name: _____ Social Security No.: _____
Last First Middle Initial

Relationship to Patient: _____ Date of Birth: _____

Employer: _____ Phone No.: _____

Address: _____
Street City State Zip

Occupation: _____

Insurance Information *(to be used only if your child has been referred to Team Physical Therapy by a physician):*

Primary Insurance Carrier: _____ Phone No.: _____

Policy No./Member ID: _____ Group No: _____

Secondary Insurance Carrier: _____ Phone No.: _____

Policy No./Member ID: _____ Group No: _____

I (We) being the parent or guardian of _____, a minor, the age of _____ do hereby consent, authorize and request TEAM Physical Therapy to administer such treatment deemed advisable, necessary or requested on the above minor for the athletic injury noted above and on referral by his/her athletic trainer or coach.

I (We) agree to hold TEAM Physical Therapy free and harmless from any claims, suits for damages or complications, which result from such treatment

_____ _____ _____
Patient's Signature Financially Responsible Party's Signature Date