

GREENVILLE HOSPITAL SYSTEM – SPORTS MEDICINE SERVICES
CONSENT AND AUTHORIZATION

I, _____, parent/legal guardian of _____, authorize Greenville Hospital System (“GHS”) staff to provide my child any healthcare services offered by GHS Sports Medicine Services and to make appropriate referrals for my child to receive any additional health services that my child’s condition may indicate. To protect and improve the health of participants, GHS will provide medical professionals to provide on-site treatment and consultation to participants in this event. These services will be overseen by a physician.

In addition, in the event my child needs urgent or emergency treatment off-site, I authorize staff of GHS Sports Medicine Services to arrange for such care, including appropriate transportation. I understand that GHS Sports Medicine Services staff will contact me as soon as possible in the event my child has an urgent or emergency condition. I agree to complete all health history, family history, and other informational requests necessary for my child’s participation in this event. I consent to the release by GHS staff of information about my child’s medical condition obtained through Sports Medicine Services to physicians and other employees or agents of GHS or to whom I am referred.

I understand that I will not be charged for services rendered on-site by the medical staff, but that I or my child’s insurance carrier may be charged for services rendered by other healthcare providers. I consent for information in my child’s medical record to be released for the purpose of filing health insurance claims with third-party payers. I hereby authorize GHS to submit claims for services rendered to my child and assign to GHS my rights to any reimbursement for such services.

In consideration for the services provided to my child by GHS Sports Medicine Services, I hereby release Greenville Hospital System, its trustees, officers, employees, and agents from and against any claim, liability, cause of action or other expense arising out of the services provided by GHS Sports Medicine Services.

I have read and understand the above information and consent to my child’s participation in GHS Sports Medicine Services

Name of Parent/Guardian (please print)

Signature of Parent/Guardian

Name of Student

Witness/Date

Emergency Contact Name

Telephone Numbers Day and Night

GREENVILLE HOSPITAL SYSTEM

Name _____ DOB _____

SSN _____ Phone # _____

Address _____

Ins. Carrier _____

Claim/policy# _____ HMO/PPO (circle one)

Insurance Preferred Network/Provider _____ (If yes) Whom _____

Emergency contact _____

Phone #'s _____

Does your child have any of the following?(list details as appropriate) Yes No

Asthma	_____	<input type="checkbox"/>	<input type="checkbox"/>
Inhaler	_____	<input type="checkbox"/>	<input type="checkbox"/>
Heart condition	_____	<input type="checkbox"/>	<input type="checkbox"/>
Vision loss	_____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	_____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	_____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney condition	_____	<input type="checkbox"/>	<input type="checkbox"/>
Hearing loss	_____	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	_____	<input type="checkbox"/>	<input type="checkbox"/>
Medication Allergy	_____	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	_____	<input type="checkbox"/>	<input type="checkbox"/>

Previous injuries/surgeries (month/year)?

Date of last tetanus booster:

Is your child on any medication that is taken on a regular basis? (List)

Does your family have a primary care physician? (Name/phone #)

Does your family have an orthopaedic doctor? (Name/phone #)

My child may take any over-the-counter medication such as Tylenol®/Advil® YES NO

Parent/Guardian Signature

Date