950 Mamaroneck Avenue | White Plains, New York, 10605
T: (914) 946-4800 | F: (914) 686-3615 | www.stepinac.org

CONSENT TO TREATMENT

Print Name: _____ DOB:_____ School: Archbishop Stepinac High School

To be read and signed by the Student-Athlete and the Parent / Guardian if the Student-Athlete is under 18 years old.

1. **CONSENT FOR ROUTINE OR EMERGENCY TREATMENT:** I hereby consent to and authorize the Certified Athletic Trainers, physical therapists, occupational therapists, and physicians of Burke Rehabilitation Hospital to evaluate and treat any injury/illness that occurs during the time or as a result of my (or my child's) participation in high school athletics. This includes any reasonable and necessary preventative or emergency care, treatment, injury prevention, and rehabilitation for these injuries/illnesses.
2. **ADDITIONAL INFORMATION:**
    a. I understand that student athletes must refrain from practice when directed by school medical staff and providers. When under medical care, student athletes may not return to participation until they have received written medical clearance from a physician and are approved by the certified athletic trainer and medical director. This may occur during or at the conclusion of medical treatment. The medical director has the FINAL authority regarding participation status following injury/illness.
    b. I understand and agree that, as a student athlete, if I experience an injury/illness or change in health status it is my responsibility to inform the head coach and the certified athletic trainer, or, in their absence, an appropriate adult or staff member. Student athletes must adhere to the established injury management guidelines including rehabilitation and reassessment before being released to return to full participation.
    c. Student athletes may be referred to additional providers when recommended by the certified athletic trainer, medical director, or other medical staff. It is the responsibility of the student athlete and their parent/guardian to make arrangements for follow-up care.

The undersigned certifies that the student athlete and their parent guardian has read this form, understands its content and significance, and is competent to execute and authorized to execute it on the student athlete's behalf.

_____ _____

Student Athlete Signature **Date**

_____ _____

Parent/ Guardian Signature (If athlete is under 18 years of age) **Date**

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION-MINOR

Print Name: _____ DOB:_____ School: Archbishop Stepinac High School

To be read and signed by the Student-Athlete and the Parent / Guardian if the Student-Athlete is under 18 years old.

I hereby authorize Burke Rehabilitation providers to disclose to Archbishop Stepinac High School (including athletic coaches and/or other School or District officials) my child's Protected Health Information (written and/or verbal) created or obtained by Burke Rehabilitation Hospital providers and staff in the course of conducting athletic training, rehabilitation and medical services. This disclosure is made at my request.

Burke Rehabilitation providers and staff may disclose any and all information which it has created or obtained regarding my child's care through athletic training, rehabilitation and medical services (including, but not limited to information involving the nature and treatment of any injury/illness, medical history, concussion testing results, insurance coverage and copies of all hospital and medical records). I understand and acknowledge that:

1. I can revoke this Authorization at any time by giving my written revocation to Archbishop Stepinac High School at the following address: 950 Mamaroneck Ave, White Plains, NY 10605. My revocation is not effective as to disclosures already made and actions already taken in reliance upon this Authorization.
2. Burke Rehabilitation Hospital may NOT condition treatment, enrollment, or eligibility for benefits on whether I sign this Authorization.
3. I am authorizing disclosure of information protected under federal law. This information, once disclosed, may be subject to re-disclosure by the recipient and no longer be protected by state or federal law.
4. This Authorization is effective for five (5) years from the date on which it is signed.
5. A photocopy or exact reproduction of this signed Authorization shall have the same force and effect as the original.

_____ _____

Student Athlete Signature **Date**

_____ _____

Parent/ Guardian Signature (If athlete is under 18 years of age) **Date**