CONSENT TO SCHOOL PHYSICAL EXAMINATION

ATHLETE'S NAME: _____
ATHLETE'S ADDRESS: _____
ATHLETE'S PHONE NUMBER: _____
SCHOOL: _____

Consent to Treat: I hereby consent for the Student Athlete listed above to undergo a basic sports physical examination to meet the School team eligibility requirements, and I consent for this examination to be conducted by employees of Tanner Health System, Inc. (THS), Tanner Medical Center, Inc., Southern Therapy Services, Inc. and/or their physicians or physicians' assistants/nurse practitioners (acting under supervision of a Physician) ("Provider").

No Guarantee. I understand that the sports physical examination to be provided will be a basic examination and may not detect potentially all dangerous medical conditions that Student Athlete may have or that could be worsened by sports activity. I understand the examination to be provided will include [INSERT]. It will not include more thorough testing, such as [EKG, blood work, cardiac stress testing, MRI, CT scan, x-ray, [INSERT]. I also understand that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made by anyone that this examination will detect any or all hazardous physical or mental health conditions.

Private Physicians. I acknowledge that some or all of the Providers performing these services are independent contractors and are not THS agents or employees. Independent contractors are legally responsible for their own actions, and I agree that THS and its affiliated entities shall not be liable for the acts or omissions of any such independent contractors.

Separate Complete Physical; Notify School. I understand it has been recommended by Provider that a full physical be done at least yearly by Student Athlete's fulltime physician who has cared for Student Athlete over time and has access to a complete medical history. I understand it is my responsibility to obtain a more thorough examination beyond the one authorized by this consent, if I feel that is prudent and/or warranted under the circumstances. I understand I should notify Provider of any medical concerns prior to the start the examination.

Consent to Release Medical Records: Other health care providers may request Provider disclose Student Athlete's diagnosis or other medical information for treatment purposes. I authorize Provider to release information acquired in the course of the sports physical examination for treatment purposes. I understand that information concerning alcohol, substance abuse, mental health, HIV or AIDS examination and treatments may be released.

Community Service: I understand this sports physical examination is performed at no charge by volunteers as a community service. I understand I am not required to use Provider's services for this basic exam or for follow-up exam/treatment but instead may choose to select my own private physician, for which I may be charged a fee.

_____	_____
Signature of Athlete (If 18 years of age or older)	Date
_____	_____
Signature of Parent or Guardian (If under 18 years of age)	Date
_____	_____
Witness	Date