



PERMISSION TO TREAT

STUDENT'S NAME: _____

SPORT: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

Permission is hereby granted to Northwood University to proceed with any needed medical or minor surgical treatment, x-ray exams and immunizations for the above name student. In the event of serious illness, the need for major surgery or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me in the most expeditious manner possible. If said physician is unable to communicate with me, the treatment necessary for the best interest of the above named student may be given.

SIGNATURE: _____

HOME or LOCAL PHONE: _____

WORK or CELL PHONE: _____

ACCEPTANCE OF RISK

I, _____ am aware of and accept the risk of injury associated with the intercollegiate sports in which I will be participating. I will do my part to reduce the injury risk by keeping myself in the best possible physical condition and to follow the advice of the team physician, athletic trainer, and/or coach concerning the prevention, treatment, and rehabilitation of athletic injuries.

AGE: _____

SIGNATURE: _____

DATE: _____