



## PERMISSION TO PROVIDE MEDICAL TREATMENT AGREEMENT

I, \_\_\_\_\_, hereby give my permission to undergo treatment for any injury or illness I may sustain or acquire while engaged in intercollegiate athletics at Indiana University of Pennsylvania. I understand that the medical personnel of Indiana University of Pennsylvania, including athletic trainers, nurses, and team medical consultants will perform only those procedures which are within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. In the event that more serious medical treatment is required, such as surgery or other invasive procedures, and I am unable to consent, I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I have had the opportunity to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Permission to Provide Medical Treatment Agreement.

_____ Athlete's Signature	_____ Date
_____ Athlete's Printed Name	_____ Date of Birth

*(Parent/Guardian please complete the section below if the athlete is under the age of 18.)*

I hereby give my permission for my son/daughter, \_\_\_\_\_, To undergo medical treatment for any injury or illness he/she may sustain or acquire while engaged in intercollegiate athletics at Indiana University of Pennsylvania. I understand that the medical personnel of Indiana University of Pennsylvania, including athletic trainers, nurses, and team medical consultants will perform only those procedures which are within their training, credentialing, and scope of professional practice to prevent, care for, and rehabilitate athletic injuries. In the event that more serious medical procedures are required, such as surgery or other invasive procedures, I understand that attempts will be made to contact me for my consent. I understand that if my child suffers a potentially life threatening injury or illness, and in the event I am unable to be contacted within a reasonable period of time, that I authorize any duly licensed medical practitioner to perform such procedures as may be medically necessary to alleviate the problem.

I have had the opportunity to ask questions regarding this release and all of my questions have been answered to my satisfaction. Having understood the above agreement, I freely sign this Permission to Provide Medical Treatment Agreement.

_____ Parent/Guardian Signature	_____ Date
_____ Parent/Guardian Printed Name	_____ Date of Birth