Northfield High School

CONSENT FOR RELEASE

OF HEALTH INFORMATION

Student-Athlete Name: _____

First Last Middle Initial

Date of Birth: ____/____/____ Age: _____

I hereby grant permission to Parkview Wabash Hospital Athletic Trainers to release to the student athlete's parents, any health care professional involved in the care of the student athlete, school administrators, and the student athlete's coach the nature of any athletic-related injury or illness and the expected rehabilitation period, if any, for purposes of addressing participation in athletic activities. This information may also be released to:

Other (Specify): _____

_____ _____

Signature of Student Athlete Date

_____

Signature of Parent or Guardian if Student is a Minor