SAINT JOSEPH HEALTH SYSTEM

Athletic Training Consent Form

Consent to Treat
I understand that Saint Joseph Regional Medical Center, Inc. (SJRMC) contracts with the student athlete's school to provide athletic training services. These services are provided by certified athletic trainers (ATs) who practice, according to state statutes, and who assess, treat, and rehabilitate student-athletes' injuries and conditions.

I give permission for the ATs and their staff to assess, treat, and rehabilitate the student-athlete and refer the student-athlete to a physician or emergency room as appropriate.

Additionally, if the ATs believe the best way to assess, treat, and rehabilitate the student-athlete is through electrical stimulation or ultrasound, I authorize the ATs to utilize these methods. Electrical Stimulation is a modality/rehabilitation tool that provides currents which can reduce pain associated with an injury. Ultrasound is also a modality used primarily to produce an increase in muscle temperature.

Further, I authorize SJRMC to utilize a baseline concussion testing program through Cogstate Healthcare, LLC and share that information with any medical personnel directly involved in the student-athlete's care for the process of making return to play decisions. Information regarding this testing program can be found by going to https://www.cogstate.com. I also give my permission for the ATs to contact the student-athlete through email with information regarding the administration of this test.

Acceptance of Risk and Release of Liability
I understand the risks involved in athletics range from minor to severe. I recognize the possibility that the student-athlete might die, become paralyzed, suffer from brain damage, or other serious, permanent injury as a result of participating in sports. I realize that neither the protective equipment and padding used in the sport, the safety rules and the procedures of the sport, the coaching instruction received, nor the athletic training care provided to student-athletes will guarantee safety or prevent injuries they might sustain. I further agree to accept these risks as a condition of the student-athlete's participation in sports. I agree not to hold the ATs responsible for any injury, loss, or damage that occurs to the student-athlete as a result of sports participation.

Additionally, as a condition to the ATs assessing, treating, and rehabilitating the student athlete, I hereby release SJRMC and its affiliates, directors, officers, employees, agents and contractors and any other organization(s) associated with SJRMC, together with their successors and assigns, from any liability arising from or related to the potential risks associated with the ATs assessing, treating, and rehabilitating the student-athlete.

Inquires
I have been given an opportunity to ask any questions about treatment the student-athlete may receive from the ATs and my questions have been answered to my full satisfaction. I have read this form or have had it read to me if unable to do so.

Medical Centers

Mishawaka Medical Center
5215 Holy Cross Pkwy.
Mishawaka, IN 46545
574.335.5000

Rehabilitation Institute
60205 Bodnar Blvd.
Mishawaka, IN 46544
574.335.8800

Plymouth Medical Center
1915 Lake Ave.
Plymouth, IN 46563
574.948.4000

Senior Services

Holy Cross
17475 Dugdale Dr.
South Bend, IN 46635
574.247.7500

Saint Joseph PACE
250 E. Day Rd.
Mishawaka, IN 46545
574.247.8700

St. Paul's
3602 S. Ironwood Dr.
South Bend, IN 46614
574.284.9000

Trinity Tower
316 S. Dr. Martin Luther King Jr. Blvd.
South Bend, IN 46601
574.335.1900

VNA Home Care
3838 N. Main St., Ste. 100
Mishawaka, IN 46545
574.335.8600

510 W. Adams St., Ste. GL-50
Plymouth, IN 46563
574.335.7950

Community-Based Programs

The Foundation
707 E. Cedar St., Ste. 175
South Bend, IN 46617
574.335.4540

Health Insurance Services
5215 Holy Cross Pkwy.
Mishawaka, IN 46545
1.855.88.SJMED (1.855.887.5633)

Outreach Services
215 W. 4th St., Ste. LL201
Mishawaka, IN 46544
574.335.3898

Physician Network
707 E. Cedar St., Ste. 220
South Bend, IN 46617
574.335.8758

SAINT JOSEPH
HEALTH SYSTEM

Statement of Permission
I fully understand its terms and sign it freely and voluntarily, without inducement. With my signature below, I voluntarily give permission to the appropriate AT and/or appropriate staff to assess, treat, and rehabilitate the student-athlete as needed. I understand that this consent will be in effect as long as the student-athlete is enrolled in the school corporation. I have read and agree to all of the above statements.

Printed Name of Student-Athlete:
_____

Signature of Student-Athlete or Student-Athlete's Representative (if Student-Athlete is under age 18)
_____

Date:_____

Relationship of Representative to Student-Athlete if applicable:
_____

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