St Luke's Orthopaedic Specialists

St Luke's Sports Medicine

Consent to Treat Patient

St. Luke's University Health Network: Sports Medicine Relationships

CONSENT TO TREAT:

I am the parent/legal guardian of the child named below and have the legal right to consent to permit St. Luke's University Health Network and its personnel to deliver health care and treatment to my child at _____ ("Program") practices and games by its athletic trainers, physical therapists and physicians. Such health care and treatment may include medical evaluation of injuries, administration of first aid for athletic injuries, and providing initial treatment and management of injuries, as may be deemed necessary or advisable by St. Luke's personnel in the treatment and diagnosis of my child. I understand that this consent will remain in effect until my child ceases to be a member of the Program or until this consent is revoked by me by sending a written notification to St. Luke's, 1441 Schoenersville Road, Bethlehem, PA 18018, Attention: Senior Director, Sports Medicine Relationships.

Child's Name: _____ Date of Birth: _____

LIMITATIONS:

Identify any specific limitations or exclusions for which this consent is given. (If none, state "none".)

_____

Parent/Legal Guardian Name (print) _____

Relationship: _____

Parent/Legal Guardian Address:

_____

City: _____ State: _____ Zip: _____

Parent/Legal Guardian Emergency Contact Number (First): _____ - _____ - _____

Parent/Legal Guardian Emergency Contact Number (Second): _____ - _____ - _____

Parent/Legal Guardian Signature:_____ Date: _____