

**Mount Si High School Sports Medicine Program
Sports Physical Consent Form**

The Mount Si Sports Medicine Program is offering pre-participation sports physicals Tuesday June 3, 2008 from 6:00 – 8:00 PM in the Mount Si High School Auxillary Gym. Physicals are good for the 2008-2009 and 2009-2010 school years. You do not need to make an appointment just show up anytime between 6pm and 8pm but if you have any questions please call Robin Backstrom ATC at 425-831-8211 you may also leave a message at this number and I will return your call as soon as possible.

Several medical professionals from the community will be donating their services, including sports and Family Physicians, Physical Therapists, Certified Athletic Trainers and MSHS Student Athletic Trainers.

The cost is \$25 per athlete and all the proceeds will go directly to the Mount Si Sports Medicine program. **All paperwork must be turned in before the athlete can get their physical.**

Students wishing to participate in the physicals must provide the following or a physical will not be performed:

1. \$25 (checks may be written out to MSHS)
2. Signed parent/guardian consent form
3. Completed Medical History – please be sure to **EXPLAIN ALL YES ANSWERS BRIEFLY** in the area provided
4. Arrive in appropriate attire – gym shorts & t-shirts. (Girls should also have on a sports bra)

Consent Form

I _____ am the legal guardian for _____ and hereby authorize the sports medicine team and other certified medical personnel gathered at Mount Si High School, to conduct a pre-participation physical exam on the above named student athlete. I understand that this exam is conducted only as a pre-participation for athletics and in no way constitutes a formal physician-patient agreement. I also understand that this exam is strictly designed to determine difficulties, which may arise with athletic participation and does not represent a complete physical exam designed to detect rare or occult diseases.

If a medical problem is discovered which will require further medical care, I wish the following physician to be notified:

Name: _____

Address: _____

Phone: _____

Athlete Signature

Date

Parent Signature

Date