

Release of Medical Information

I hereby authorize and request all my current or prior physicians to disclose, whenever requested to do so, to the athletic training/sports medicine staff (including athletic trainers, medical, orthopedic or other medical specialty consultants), any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatments, including medical imaging and copies of all hospital and medical records. This release remains valid until revoked in writing. I understand that these records will remain confidential, be maintained in my child's medical file, and will only be shared with people involved in the care of the athlete. A copy shall be considered as valid as the original.

Agreed to: _____

(Print students name)

(Students Signature) (Date)

(Parents Signature) (Date)

Over the Counter Medication

I hereby authorize the Lewisville Independent School District Licensed Athletic Trainers to administer to my minor child over the counter medication according to the directions contained on the medication.

(Parents Signature) (Date)