INSTITUTE OF ATHLETIC HEALTH CARE AND RESEARCH, INC.

Dear Parent

The **Institute of Athletic Health Care and Research, Inc.** is a non-profit volunteer organization designed to improve the athletic health care in our community by providing service education and research in this field. As a service, annual athletic physical exams are offered by the Institute.

- A **$10.00** exam fee per student is charged **Five dollars** from each exam will be returned to the student's specific athletic program to provide for athletic health care equipment and supplies.

- Time Place and Date schedules for each school will be sent to the team coaches. It is the coach s responsibility to have his or her team at the exam facility on time.

- **All examinees must wear shorts, t-shirts, socks and tennis shoes.**

As the parent/guardian of _____, my child or ward (hereinafter, collectively, "child"), I hereby give my permission to the following:

1. Examination of my child by the Institute of Athletic Health Care and Research, Inc.

2 The information contained in this physical examination is used exclusively for the participation of the athlete in his/her high school sports activity and will ONLY be released to the following:

a) A bona fide representative of the Institute of Athletic Health Care and Research, Inc. for research purposes.

b) To a physician administering emergency treatment to my child.

c) To a hospital, health care facility or emergency care facility administering treatment to my child.

DATE:_____ SIGNATURE: _____
Parent or Legal Guardian

PRINT NAME:_____
Parent or Legal Guardian

**** PLEASE COMPLETE THE MEDICAL HISTORY FORM PRIOR TO REPORTING ****