EVANSTON
REGIONAL HOSPITAL

PARENTAL CONSENT

I, _____, hereby consent to authorize the professional staff of Evanston Regional Hospital's Physical Therapy Department to provide a pre-season injury screening including diagnostic services, therapeutic services including assessments. I acknowledge that I may at any time request my student's information from Evanston Regional Hospital Physical Therapy Department.

I acknowledge that I have read this consent (or have had this consent read to me) and understand its contents.

Student Signature _____

Student Name (Print) _____

Date _____

If the patient is a minor (under the age of 18) or the patient is unable to sign or give consent-

Signature (Legal Guardian) _____

Print Name _____

Date _____

Please Select:

☐ **Parent**

☐ **Legal Guardian**