



CONSENT FOR CARE AND TREATMENT

I am the parent or legal guardian of _____,
a minor. I acknowledge that Apple Therapy Services and the Safe Sports Network provide certain athletic injury care services. I hereby consent to Apple Therapy Services and the Safe Sports Network's performance of these services for my child, including injury screening and treatment. I understand that the screenings and treatment will be conducted by a licensed athletic trainer or medical practitioner.

Date

Parent or Guardian Name (please print)

Signature of Parent or Guardian

Medical Director: James C. Vailas, MD • Director: Laura C. Decoster, ATC, NHLAT • Assistant Director: Michael B. Hardy, MBA, ATC, NHLAT

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