Permission to Treat

Student/Athlete's Name: ______________________________________ DOB: ___/___/___

Permission for Medical Treatment

Permission is hereby granted to Ortho Montana/AMP medical professional staff, including the Licensed Athletic Trainers, Physicians, and Therapists to examine and treat any injury/illness sustained by the above athlete. Permission is also granted to conduct pre-participation physical examinations without parent/guardian being present.

This permission covers the student/athlete for the period of one year from the date of signature.

Every effort will be made to contact the parent/legal guardian prior to treatment if necessary.

Athlete Signature: ____ Date: _____________

Parent/Legal Guardian Signature: ____ Date: _____________

Required if the participant is under the age of 18.

Parent/Legal Guardian Phone Contact Numbers:

Contact Name: ___________________________________ Relationship to Athlete: ______________________
Work: ____ Home: ______________________________________
Cell: ____ Other: ______________________________________

Contact Name: ___________________________________ Relationship to Athlete: ______________________
Work: ____ Home: ______________________________________
Cell: ____ Other: ______________________________________

Please notify Ortho Montana staff if the contact numbers change.

Ortho Montana
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