



Consent for Health Screening

By signing below, I release Adventist Health / Central Valley Network, Adventist Health / Community Care, Adventist Medical Centers Hanford, Selma and Reedley and Physicians Network from all liability resulting from Pre-Participation Physical Evaluations, Functional Movement Screenings, and other types of Health Testing.

I acknowledge that I have been made aware of the following health care evaluation and screenings, and **consent** to allow my athlete to participate in a Pre-Participation Athletic Physical Evaluation.

Student/Athlete Information:

Name: _____

Address: _____

City: _____ Phone: _____

Date of Birth: _____ Primary Care Physician/Provider: _____

Parental/Legal Guardian Consent:

I understand that:

1. Only the pre-participation athletic physical card supplied by the school will be shared with the athlete's school, not the specific results from the Physical Evaluation, and/or other types of Health Screenings.
2. If the athlete is not cleared to participate by the provider, it is my responsibility to initiate a follow-up examination(s) to confirm abnormal findings, and obtain diagnosis and treatment from my athlete's primary care physician.
3. My athlete's participation in this screening is voluntary.

I have read this form, and I give my full consent to allow my athlete to participate in the evaluations, testing, and screenings.

Date: _____ Parent/Guardian Signature: _____

If your athlete does not have a Primary Care Physician/Provider, and would like more information on local providers in the area please ask for a physician directory.