STUDENTS & PARENTS/GUARDIANS:
When you have read and thorougly understand this information, please sign and return this form to school. If you have any questions or concerns, call the Athletes Advantage sports medicine program at St. Joseph's Hospital in Breese at (618)526-5630.

CONSENT TO TREAT

I (we) understand that St. Joseph's Hospital in Breese, when requested, from time to time, will provide a member of its staff to offer sports medicine services to the student athletes during practices, meets and games. I authorize members of the Athletes Advantage sports medicine program to assist me/my student athlete with medical care, treatment and training.

In the event of an injury or accident to myself/this student during participation in an athletic activity, school officials are authorized to seek immediate medical attention or assistance at the nearest medical facility, if deemed appropriate.

I understand that the staff of the Athletes Advantage sports medicine program are not employed, controlled or supervised by the school. By signing this form, I agree to indemnify and hold harmless the school, its Board of Education, all individual members of its Board (past, present and future), its employees, chaperones, officers, agents, successors and assigns, from any and all matters of action, causes of action, grievances, rights or claims of rights, debts, dues, damages, liabilities, costs, claims, controversies, demands, torts, contracts, agreements, guarantees, indebtedness, obligations, expenses, accountings, warranties and chooses in action, in law or in equity, and of every nature and description whatsoever by reason of or in respect to any act, cause, matter, omission, right, duty, injury, or thing that may have or has arisen with regard to the staff of St. Joseph's Hospital's Athletes Advantage sports medicine staff's treatment of, or contract with, my student athlete, whether known or unknown, suspected or unsuspected, latent or patent.

This consent will remain in full force and effect until revoked by the undersigned,

Father ______________________________ Date ______________

Mother ______________________________ Date ______________

Legal Guardian ______________________________ Date ______________

Student ______________________________ Date ______________

PHOTO/INFORMATION/MARKETING RELEASE

I hereby give St. Joseph's Hospital the unqualified right and permission to reproduce, copyright, publish, circulate, or otherwise use photographic reproductions or likenesses, as well as identifying information of name, school, grade, sport and position, parents' names and hometown. This authorization and release covers the use of said material in any published form, and any medium of advertising or publicity.

I also give St. Joseph's Hospital the right to contact me/my student athlete with training/camp opportunities, special offers, clinics and events, promotions, and solicitations. I (we) understand that we may opt out of receiving said materials by calling (618)526-5630 and confirming removal from the mailing list.

Father ______________________________ Date ______________

Mother ______________________________ Date ______________

Legal Guardian ______________________________ Date ______________

Student ______________________________ Date ______________

TEACHERS/OFFICE PERSONNEL: Please route this form to the Athletic Trainer via Athletic Director's office. Thank you!