SPORTSMEDICINE FAIRBANKS  
Lathrop High School  
Athletic Training / Sports Medicine Department

Permission to Treat, Consent & Authorization for Release of Medical 
Records, and Acceptance of Risk Form

Student Athlete Name: ________________________________________________________

PERMISSION FOR MEDICAL TREATMENT
Permission is hereby granted to Christopher D. Dean, BS, ATC, Head Athletic Trainer, and other certified athletic 
trainers when the LHS Head Trainer is unavailable, and other trained medical professionals during emergencies to proceed 
with any medical treatment, either minor or emergency, deemed necessary in the event that the above named student-
athlete sustains an injury/illness during participation in interscholastic athletics for Lathrop High School. This permission 
for medical treatment covers the period of the entire school year 2003-2004 terms through July 31, 2004 for all games, 
practices, activities, events, etc.

Permission is also hereby granted to the LHS Team Physician, Cary S. Keller, M.D., FACSM and/or other 
attending physicians and medical professionals to proceed with minor or emergency medical or surgical treatment for the 
previously named student-athlete. I understand that every effort will be made by the physician/medical professional to 
contact me prior to treatment.

CONSENT & AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS
Permission is hereby granted to Christopher D. Dean, BS, ATC, Head Athletic Trainer, the Team Physician, Cary S. 
Keller, M.D., FACSM or any other medical consultant of Sportsmedicine Fairbanks to examine medical records concerning 
examination or treatment received by the above named student-athlete for the express purpose of evaluating a medical emergency 
or the medical or physical fitness for participation in, or continued participation in interscholastic athletics for Lathrop High 
School. Permission is also granted to furnish Sportmedicine Fairbanks and the Athletic Training / Sports Medicine Department at 
LHS with any reports or copies of the student athlete’s medical records that the medical professional may request. I understand 
that these medical records may be shared with the athlete, his/her legal guardians/parents, other medical providers and LHS 
Athletic Trainers, Coaches, Athletic Director, and School Nurse in order to provide them with recommendations for, and to 
provide medical treatment for the student-athlete. I understand that information released may no longer be protected by state and 
federal privacy laws and regulations.

ACCEPTANCE OF RISK
We are aware of, and accept, the risk of injury associated with participation in interscholastic athletics for Lathrop High 
School. As a student-athlete, I will do my part to reduce the risk of injury by keeping myself in the best possible physical and 
mental condition and will follow the advice of the Team Physician, Head Athletic Trainer, and Coach concerning the prevention, 
evaluation, treatment, and rehabilitation of athletic injuries. I agree to be honest in my participation in athletics at LHS and to 
report any and all illegal activities to the appropriate authority.

Student-Athlete Signature: _______________________    Date:  _______ 

Parent/Guardian/Legal Representative Signature ______________________   Date: _______

Parent/Guardian Phone Contact Numbers: Work _______   Home _______   Cell __________
Pager __________________ Other ____________ Please notify Trainer immediately if 
contact numbers change.

SMF ATC School Term Consent for Treatment 
Medical Records Release