ATHLETIC INFORMATION

We would like to keep your coach and/or athletic trainer from your school and/or club updated on your progression. Please provide the following information if applicable:

Name: _____ Sport(s): _____

School/College: _____ Grade: _____

School Coach Name: _____ Email or Phone: _____

Club Coach Name: _____ Email or Phone: _____

Athletic Trainer Name: _____ Email or Phone: _____

Is there anyone else you would like us to talk to or update regarding your progress (ie: club coach, parent –if over 18)? Yes No

If yes, please list:

Name: _____ Email or Phone: _____

Name: _____ Email or Phone: _____

Name: _____ Email or Phone: _____

Did your coach or athletic trainer from school tell you about SCAR? Yes No

If no, how did you hear about our program?

Please circle: Family member Friend Doctor Other: _____

Name of referral _____ Email or Phone: _____

I give my permission to the athletic trainers and physical therapists at SCAR to communicate with any of the persons named above. By signing below I also give my permission to release my athletic training or physical therapy information and records.

_____

Patient/Guardian Signature Date

_____

Parent Signature (If athlete is under the age of 18)

SPORTS CONDITIONING AND REHABILITATION
www.scarfitness.com info@scarfitness.com
871 S. Tustin St. Orange, CA 92866 714-633-7227

SCAR
Sports Conditioning and Rehabilitation
Get Healthy. Stay Healthy. Play Healthy.

INJURY CONSULTATION CONSENT FORM

DATE_____

NAME_____ PHONE_____

ADDRESS_____

E-MAIL ADDRESS_____

EMERGENCY CONTACT_____ PHONE_____

REFERRED BY_____

HIGH SCHOOL/COLLEGE:_____ GRADE:_____

COACH:_____ SPORT(S):_____

CLUB COACH INFORMATION_____

I, _____hereby request and consent to the consultation for the following physical concern (injury):_____; and hereby consent to the performance of specific testing and therapeutic procedures as deemed necessary and as performed by a an athletic trainer and/or physical therapist at Sports Conditioning and Rehabilitation of California, Inc. and their associates for the aforementioned problem. I understand, and am informed that, while extremely rare, there are some risks associated with testing procedures and therapeutic intervention. I understand that the purpose of the testing and therapeutic procedures will be explained to me prior to receiving treatment and that I may refuse any therapeutic procedure or treatment at any time.

I hereby acknowledge that I am a willing participant in this consultation; and understand and agree to the information presented above.

_____ _____

Participant Signature DATE

_____ _____

Signature of parent/guardian if participant is under 18 years old DATE

Office use only

AT/PT initials:_____

Consultation Outcome:_____

_____

Recommendations:

PT:_____ SCIP:_____ Physician Referral:_____ RTP:_____ Other:_____

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