



ILLINI SPORTS MEDICINE

301 W. Lincoln, Suite 210

Belleville, IL 62220

(618) 641-5800

(618) 641-5825 FAX

CONSENT FOR PHYSICAL EVALUATION AND TREATMENT

I, _____, hereby give consent to St. Elizabeth's Hospital and Illini Sports Medicine staff permission to complete a physical evaluation, diagnostic tests, to include radiology exams and laboratory tests, and treatment on my child, _____ in the event of musculoskeletal injury or medical condition as a result of participating in my child's school athletic program.

Signature

Date

Witness

Date