Capital Region®
MEDICAL CENTER
University of Missouri Health Care
Better. Every day.

RELEASE OF INFORMATION

(Please Print)

Athlete's
Name:_____

Date of Birth:_____ Grade in School_____

Sport or Sports:_____

I hereby authorize the Capital Region Medical Center Athletic Trainers and/or Team Physicians to release information regarding the health status of myself (over 18 years of age) or my son or daughter to their coaches/athletic directors as it relates to their ability to participate in sports, including information regarding the care and treatment of their injuries and/or illnesses, their condition, the prognosis, for statistical reporting of sports injuries and to meet required MSHSAA (Missouri State High School Athletics Association) guidelines/protocols.

This release will be in effect for the period of time I/they participate in sports with _____ (High School/Club Sports Team/PAL league) but for no longer than 4 years from date of signature.

I understand that I have the right to revoke this authorization, in writing, at any time, except for information required to meet MSHSAA guidelines/protocols. I understand that a revocation is not effective to the extent that any person as already acted in reliance on my authorization. I understand that Capital Region Medical Center will notify the coaches this authorization has been revoked.

Signature:_____ Date:_____

_____

Relationship to Student if Signed on Behalf of Student Under the Age of 18