**Santa Barbara City College**

**ATHLETICS**

**ACKNOWLEDGEMENT OF HEALTH SCREENING**

I am aware that I am obtaining a pre-participation athletic health screening, which will allow me to participate in intercollegiate athletics. I realize that the health screening is not as thorough as a physical exam and should not be assumed to be a complete physical exam.

**NAME OF ATHLETE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF ATHLETE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF UNDER 18 YEARS OLD:**

**SIGNATURE OF PARENT/LEGAL GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_**

**CONSENT TO TREAT**

I give permission for the Host Certified Athletic Trainer(s) to evaluate, provide necessary treatment and/or referral to a physician for any injuries or illnesses that occurs as a result of my participation on an intercollegiate athletic team offered through Santa Barbara City College. This participation may include practices, competition and/or traveling with an intercollegiate athletic team at Santa Barbara City College.

**NAME OF ATHLETE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF ATHLETE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF UNDER 18 YEARS OLD:**

**SIGNATURE OF PARENT/LEGAL GUARDIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_**