



1760 COUNTY ROAD J WAHOO, NE 68066

402.443.4191 402.443.1427

[WWW.SAUNDERSMEDICALCENTER.COM](http://WWW.SAUNDERSMEDICALCENTER.COM)

## SPORTS PHYSICAL CONSENT FORM

Student Name \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Phone Number \_\_\_\_\_ School \_\_\_\_\_

The above student has my consent to receive a sports physical, as required by his/her school, from Saunders Medical Center.



Our HIPAA Notice of Privacy Practices is available on our web site at [www.saundersmedicalcenter.com](http://www.saundersmedicalcenter.com); it is also available at the Saunders Medical Center Clinic. If you would like a copy, please check the box below and a notice will be mailed to you. Your signature confirms that you have been given an opportunity to review our Notice of Privacy Practices.

Yes, Please mail the Notice of Privacy Practices to the above address.

Parent or Guardian of Student (Please Print) \_\_\_\_\_

Signature of Parent or Guardian \_\_\_\_\_

Date \_\_\_\_\_