SAUNDERS Medical Center
1760 COUNTY ROAD J, WAHOO, NE 68066
(402) 443-4191 OR (888) 501-4762
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.

SAUNDERS Medical Center

Saunders Medical Center's HIPAA Notice of Privacy Practices is available on our website at 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